

Investing in You

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2026 Coverage Details – COBRA – Financial Advisors & Principals

The following charts provide information about your benefit coverages, including an overview of key plan features. For full details, see the Investing in You benefits website: www.edwardjonesbenefits.com.

Medical Benefits (Network Provider: Anthem Blue Cross)				
	GOLD Medical Plan		SILVER Medical Plan	
Plan Features	Network Provider	Out-of-Network Provider ¹	Network Provider	Out-of-Network Provider ¹
Annual Deductible	\$2,000 per person, \$4,000 per family	\$4,000 per person, \$8,000 per family	\$4,000 per person, \$8,000 per family	\$6,000 per person, \$12,000 per family
	Applies to Medical, Rx and Behavioral Health expenses only. Dental and Vision expenses do not apply to deductible.			
Deductible Procedure	For dependent coverage tiers: Gold: One person or a combination of family members must meet the full family deductible before the plan starts paying 80% on family's claims. Silver: One person may satisfy the per-person deductible; then the plan will begin paying 80% on that member's claims.			
Maximum you pay including annual deductible	20% coinsurance after deductible \$4,000 per person/ \$8,000 per family Out-of-Pocket (OOP)	40% coinsurance after deductible \$7,000 per person/ \$14,000 per family Out-of-Pocket (OOP)	20% coinsurance after deductible \$6,000 per person/ \$12,000 per family Out-of-Pocket (OOP)	40% coinsurance after deductible \$8,000 per person/ \$16,000 per family Out-of-Pocket (OOP)

Both medical plans cover these services in the same manner:

Your Plan Covers:		In-Network Provider	Out-of-Network Provider ¹
Medical	Preventive Care for Adults (including one annual routine physical and well- woman exam, mammogram, breast pumps, immunizations, colonoscopy, wellness eye exam, flu vaccine, prostate screening and BRCA testing)	100%; no deductible	40% coinsurance after deductible
	Preventive Care for Children (including immunizations)	100%; no deductible	40% coinsurance after deductible
	Physician's Office Visit/Virtual Doctor Visit (medical diagnosis and treatment)	20% coinsurance after deductible	40% coinsurance after deductible
	Lab/X-ray	20% coinsurance after deductible	40% coinsurance after deductible
	In-hospital Medical Care ²	20% coinsurance after deductible	40% coinsurance after deductible
	Emergency Room Treatment ³	20% coinsurance after deductible	40% coinsurance after deductible
	Urgent Care Center/Convenience Care Clinic/ Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
	Behavioral Health	20% coinsurance after deductible	40% coinsurance after deductible
	Prenatal and Maternity Care/Newborn Care ⁴	20% coinsurance after deductible	40% coinsurance after deductible
	Manipulative Therapy ⁵ (Chiropractic)	20% coinsurance after deductible	40% coinsurance after deductible
Physical, Speech, Occupational Therapy ⁶	20% coinsurance after deductible	40% coinsurance after deductible	
Prescription Medications	Administered by CarelonRx: Retail Pharmacy – Maximum 30-day supply available for generic and brand drugs Through Mail Service – Up to 90-day supply available for generic and brand drugs	Brand ⁷ and generic covered at 80% after deductible (Women's prescription contraceptives and cancer prevention drugs for women at high risk covered 100% before deductible.)	Not applicable
	Maintenance Medications: You'll pay more if you don't switch to RxMaintenance 90 after the second refill at a retail pharmacy	If you are taking a maintenance medication you may receive the first 30-day supply and up to one additional 30-day refill of the same medication at a participating retail pharmacy. On your third refill, you must fill a 90-day supply of your maintenance medication at a participating maintenance network retail pharmacy or use the CarelonRx home delivery pharmacy. If you don't switch to the RxMaintenance 90 program: You will pay the full cost of the drug at 100% before and after your deductible is met. None of the penalty costs will be applied toward your deductible or out-of-pocket.	Not applicable
	Lifetime Maximum Benefit	Unlimited	Unlimited

¹ Charges for out-of-network providers are subject to allowed limits. The patient is responsible for amounts billed by provider that exceed the allowed amount.

² Precertification is required for all inpatient hospital care.

³ In an actual emergency, the network coverage level applies (up to allowed limit) regardless of the provider you use for emergency care. If you use an emergency room for non-emergency care, the expense is not covered.

⁴ Maternity benefit level applies only to OB/GYN services. Lab, ultrasound, etc., are covered under the Lab/X-ray benefit. For labor/delivery, refer to In-hospital Medical Care. Nursery care for well newborns is covered under the mother's in-hospital deductible.

⁵ Maximum 35 visits per year.

⁶ Maximum 20 visits per year per therapy.

⁷ If patient requests brand drugs when their doctor approves a generic, the Plan only covers cost of generic drug.

COBRA Medical Plan Monthly Rates

Coverage	GOLD Medical Plan	SILVER Medical Plan
Associate	\$713.13	\$678.31
Associate + Spouse/Domestic Partner	\$1,604.42	\$1,525.93
Associate + Child(ren)	\$1,247.89	\$1,186.84
Associate + Family	\$2,281.98	\$2,170.38

Employee Assistance Program (EAP) Plan Monthly Rates

Head of Household Elects	\$4.54
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Must be 18 years of age or older to elect this benefit. You can then invite 5 members to the platform.

Dental Plan (Network Provider: Delta Dental)

Benefit	Premium Dental Plan	Basic Dental Plan
Preventive care (twice a year cleaning, checkup, X-rays)	100%, no deductible	100%, no deductible
Annual deductible for treatment	\$75 per person/ \$150 per family	\$50 per person (no family limit)
Basic services (fillings, periodontics, root canals, simple and surgical extractions)	80% after deductible	50% after deductible
Major services (bridges and dentures, crowns, oral surgery)	50% after deductible	50% after deductible
Maximum annual benefit payable for all services, other than preventive care	\$2,000 per person	\$1,000 per person
Applies to all eligible members including associates, spouses and dependent children to age 19 or 23 full-time student (\$2000 lifetime maximum) NOTE: Orthodontia benefit paid quarterly statement and verbiage afterwards remains the same.	50% after deductible, lifetime maximum of \$2,000 per eligible member	Not covered
Coverage	Monthly	
Associate Only	\$47.94	\$27.16
Associate Plus Spouse	\$90.01	\$54.30
Associate Plus Child(ren)	\$103.80	\$56.45
Associate Plus Family	\$167.80	\$90.96

Vision Plan (Network Provider: VSP)

Benefit	Description	Co-Pay	Frequency
Well Vision Exam	Focuses on your eyes and overall wellness	\$0	Every calendar year
Contact Fitting	Contact lens exam (fitting and evaluation)	\$60	Every calendar year
Prescription Glasses Frame	\$200 allowance 20% off any amount over allowance	\$35 Included in Prescription Glasses co-pay	Every other calendar year
Lenses	Single vision, lined bifocal, lined trifocal	Included in Prescription Glasses co-pay	Every calendar year
Lens Options	• Polycarbonate lenses for children	\$0	Every calendar year
	• Standard progressive lenses	\$0	
	• Premium progressive lenses	\$95 - \$105	
	• Custom progressive lenses	\$150 - \$175	
	Average 20% - 25% off other lens options		
Contacts (instead of glasses)	• \$200 allowance for contacts	Contact lens exam (fitting and evaluation), covered in full after copay	Every calendar year
Extra Savings and Discounts	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> • Extra \$50 to spend on featured frame brands. Go to VSP.com/framebrands for details. • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision exam Routine Retinal Screening. • No more than a \$39 copay on routine retinal screening as an enhancement. Laser Vision Correction • Average 15% off the regular price or 5% off the promotional discounts only available from contracted facilities. <p>Light Care</p> <ul style="list-style-type: none"> • Frame allowance may be used for non-prescription sunglasses or blue light glasses (if not already used for prescription materials). <p>Computer Vision</p> <ul style="list-style-type: none"> • Provides additional materials benefits specific to computer use: \$35 material copay, \$200 retail frame allowance. This is an associate-only benefit; it does not apply to covered dependents. 		
Coverage	Monthly		
Associate Only	\$8.23		
Associate Plus Spouse	\$17.36		
Associate Plus Child(ren)	\$18.10		
Associate Plus Family	\$27.23		

Note: Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit www.vsp.com for details.

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