

Investing in You

Culture ▪ Career ▪ Total Rewards ▪ Well-being

Edward Jones



2024 Coverage Details – COBRA – Client Support Team & Home Office

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

Both medical plans cover these services in the same manner:

Your Plan Covers:		In-Network Provider	Out-of-Network Provider ¹
	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 Express Scripts: 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 at Retail: You'll pay more if you don't switch to mail order after the third refill at a retail pharmacy.	If you don't switch to mail order: 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	\$644.96	\$611.38
Associate + Spouse/Domestic Partner	\$1,461.80	\$1,386.25
Associate + Child(ren)	\$1,118.06	\$1,059.31
Associate + Family	\$2,114.89	\$2,007.45

Employee Assistance Program (EAP) Plan Monthly Rates	
Head of Household Elects	\$4.54

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
Orthodontia for children under age 19. Note: The orthodontia benefit is paid quarterly as the treatment plan progresses. If you drop Premium coverage during the course of orthodontia treatment, you won't receive the full \$2,000 benefit.	50% after deductible, lifetime maximum of \$2,000 per child	Not covered
Coverage	Per Pay Period Rate	
Associate Only	\$42.37	\$24.56
Associate Plus One Child	\$72.87	\$41.40
Associate Plus Two Children	\$104.73	\$58.26
Associate Plus Three Children	\$136.62	\$75.11
Associate Plus Four or More Children	\$168.49	\$92.01
Associate Plus Spouse/Domestic Partner Only	\$84.85	\$49.10
Associate Plus Spouse/Domestic Partner and One Child	\$114.19	\$65.96
Associate Plus Spouse/Domestic Partner and Two Children	\$145.72	\$82.80
Associate Plus Spouse/Domestic Partner and Three Children	\$177.60	\$99.66
Associate Plus Spouse/Domestic Partner and Four or More	\$209.49	\$116.50

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	Glasses and Sunglasses • 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 form contracted facilities		
Coverage	Per Pay Period Rate		
Single	\$6.16		
Dual	\$12.43		
Family	\$20.02		

Note: Coverage with retail change affiliate may be different, visit www.vsp.com for details.

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