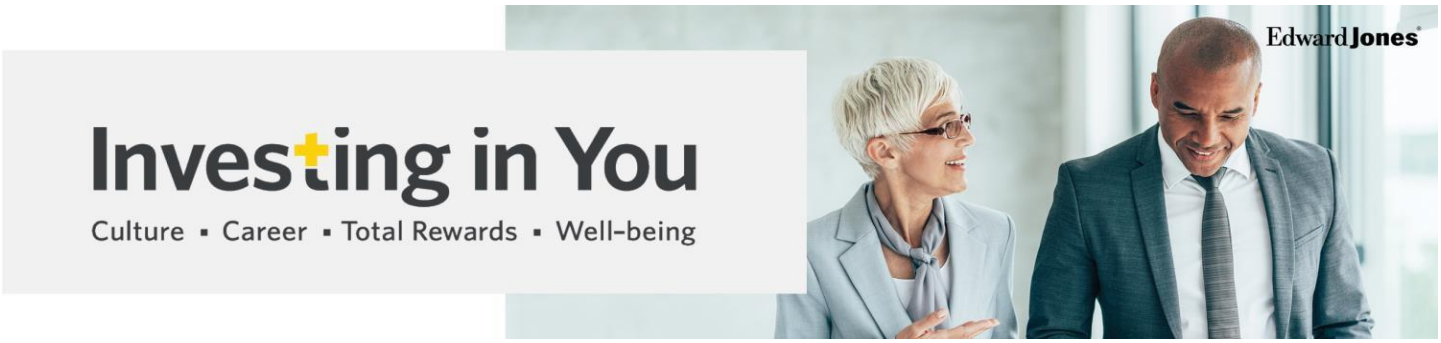

2026 Coverage Details – COBRA – Client Support Team & Home Office

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
	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	$750.31	$711.58
Associate + Spouse/Domestic Partner	$1,698.83	$1,611.70
Associate + Child(ren)	$1,302.42	$1,234.67
Associate + Family	$2,452.01	$2,328.10

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
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	$96.01	$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	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 from contracted facilities. Light Care • Frame allowance may be used for non-prescription sunglasses or blue light glasses (if not already used for prescription materials). Computer Vision • 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, visit www.vsp.com for details.

Edward D. Jones & CO., L.P. reserves the right, within its sole discretion, to amend or terminate any of its benefits at any time and for any reason, including without limit the cost-sharing provisions described herein as it applies to any current or former participant, employee or other beneficiary. Please keep a copy of this document along with a copy of the summary plan description. Complete information for benefits is found in the SPD, benefit booklets and certificates of coverage available on Investing in You, Resources, Benefit Plans and Programs Documents.