

Dental Benefits - 2023

Dental Benefits

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This section of the Summary Plan Description ("SPD") describes important information about the dental benefits offered through the Edward D. Jones & Co. Employee Health & Welfare Program (the "Plan"). For more information about the dental benefits, please consult the "Claim, Appeal, and Legal Information" section.

This SPD is effective January 1, 2023. This SPD, and other various other documents (such as relevant Plan documents, insurance policies, certificates of coverage, and other benefit summaries) currently in effect taken together are the "Plan documents". Your rights are governed by the terms of the Plan documents. Any questions concerning the Plan shall be determined in accordance with the terms of the relevant Plan documents.

The Plan Administrator retains the authority to resolve any conflict or inconsistency between the SPD and any other Plan document. No person, other than the Plan Administrator or their authorized delegate, has the authority to make any representation which contradicts the Plan documents.

Terms to Know

Annual Deductible. An amount you are required to pay each calendar year *before* benefits begin under the Plan. The annual deductible does not apply to preventive services. Your deductible for services from participating and non-participating providers is combined. That is, the deductible that applies to care received from a participating provider also applies to your non-participating deductible, and vice versa.

Annual Maximum. The maximum amount the Edward Jones Dental Plan will pay for covered services *each calendar year*. The Annual Maximum is \$1,000 for the Basic Dental Plan or \$2,000 for the Premium Dental Plan per covered person. This amount is the total amount the Dental Plan pays for covered dental expenses (not including what is paid for preventive services exams, cleanings, x-rays, and fluoride treatments), regardless of whether you use Delta Dental Participating Providers or Non-Participating Providers. Once you or your covered dependents reach this limit, you are responsible for the full cost of any additional services you may receive.

Delta Dental Participating Provider. A dentist who has signed an agreement with Delta Dental to be part of the Delta Dental PPO or Delta Dental Premier Network. When you use a Delta Dental Participating Provider, you are not responsible for paying the dentist any amount that exceeds the applicable Maximum Plan Allowance. You are only responsible for non-covered charges, any deductible and coinsurance amounts, and any amount over the Annual Maximum, if applicable.

Dental Plan. The dental coverage options available to you and your family as provided through the Edward D. Jones & Co. Employee Health & Welfare Program.

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Maximum Plan Allowance (MPA). The amount determined by the applicable Delta Dental Plan as the allowed amount for a particular procedure, service, or item for the particular dentist or service provider. Generally, the MPA will be based on the applicable Delta Dental Plan's fee schedule for the particular dentist or service provider. The allowed amount for a particular dentist or service provider depends on his or her participation status (e.g. Delta Dental PPO Participating Provider, Delta Dental Premier Participating Provider, or Non-Participating Provider).

Non-Participating Provider. Any dentist who has not signed a participating agreement with Delta Dental.

Dental Benefits Summary

To help you and your eligible dependents enjoy better dental health through regular dental care, the Edward Jones dental plans (collectively referred to as the Dental Plan) provide comprehensive coverage for preventive and other types of dental services. Both dental plans are administered by Delta Dental of Missouri (Delta Dental). Delta Dental has unique participating agreements with practicing dentists nationwide. Delta Dental Participating Providers will file your claims for you, and Delta Dental will pay the Delta Dental Participating Providers directly for covered services. This Dental Plan is part of the overall Edward D. Jones & Co. Employee Health and Welfare Program.

Generally, here is how the Dental Plan works. Services other than preventive services are subject to an annual deductible. After you have met the annual deductible, benefits will be payable for eligible expenses up to the annual maximum benefit (defined under the above *Terms to Know* section). The annual maximum benefit payable includes amounts paid by the Plan for some Preventive Services. To be eligible for benefits, you must be enrolled in the Dental Plan. Payments will not be made until Delta Dental receives a claim form for the services your dentist provides (see the *Claim, Appeal, and Legal Information* section for more information).

Dental Plan Highlights

The following chart gives you an overview of the benefits available to you through the Dental Plan. A choice of two plans is offered to eligible associates.

Basic Dental Plan

Annual Deductible	\$50 per person
Preventive Services	100%, no deductible
Basic Treatment	50% after deductible
Major Treatment	50% after deductible
Maximum annual benefit*, not including some preventive services	\$1,000 per person

Premium Dental Plan

Annual Deductible	\$75 per person, maximum \$150 per family
Preventive Services	100%, no deductible
Basic Treatment	80% after deductible
Major Treatment	50% after deductible
Maximum annual benefit*, not including some preventive services	\$2,000 per person
Orthodontic** benefit for children under age 19	50% coverage after annual deductible, up to \$2,000 lifetime maximum benefit per child

* Benefits for exams, cleanings, x-rays, and fluoride treatments do not apply towards your annual maximum benefit. Other preventive services, like emergency palliative treatment or space maintainers, do count towards the annual benefit maximum.

****Orthodontia 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 benefit up to the \$2,000 lifetime maximum.

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Selecting Your Dentist

You may visit the dentist of your choice and select any dentist on a treatment-by-treatment basis. It is important to remember your out-of-pocket costs may vary depending on your choice. You have three options:

1. **PPO Participating Dentist (Delta Dental PPO Network).** Delta Dental's PPO network consists of dentists who have agreed to accept payment based on the applicable PPO Maximum Plan Allowance as payment in full and to abide by Delta Dental policies. This network offers you cost control and claim filing benefits. Your out-of-pocket expenses may be lower with a PPO provider.
2. **Non-PPO Participating Dentist (Delta Dental Premier Network).** Delta Dental's Premier network consists of dentists who have agreed to accept payment based on the applicable Premier Maximum Plan Allowance as payment in full and to abide by Delta Dental policies. This network also offers cost control and claim filing benefits over a non-participating dentist; however, your out-of-pocket expenses may be higher with a Premier dentist, based upon your plan design.
3. **Non-Participating Dentist.** If you go to a non-participating dentist (not contracted with a Delta Dental plan), Delta Dental will make payment directly to you based on the applicable Maximum Plan Allowance for the non-participating dentist. If your Non-Participating Dentist charges more than the Maximum Plan Allowance, he or she may bill you the difference between these amounts. It will be your obligation to make full payment to the dentist and file your own claim. Obtain a claim form from www.deltadentalmo.com.

Advantages of Selecting Participating Dentists

All participating dentists (both PPO and Premier) have the necessary forms needed to submit your claim. Delta Dental participating dentists will usually file your claims for you and Delta Dental will pay them directly for covered services. Visit www.deltadentalmo.com to find out if your dentist participates or contact Delta Dental to automatically receive, at no cost, a list of PPO and Premier participating dentists in your area. Unlike Non-Participating Dentists, when you receive care from a Participating Dentist, you are not responsible for paying the Participating Dentist any amount that exceeds the PPO or Premier network Maximum Plan Allowance, whichever is applicable. You are only responsible for any non-covered charges, deductible and coinsurance amounts.

To find a Delta Dental Participating Dentist near you, visit the online provider directories. You may access it on the web at www.deltadentalmo.com, then click on "Find a provider" followed by "Find a Dentist", then choose Delta Dental PPO or Delta Dental Premier. You may also request a copy from Delta Dental free of charge. Your out-of-pocket expenses may be lower if you use a PPO or Premier network provider.

Identification Cards

After you enroll for dental coverage, you will receive a letter with two dental identification cards attached. You must present this ID card at your dentist's office when receiving dental care from a Delta Dental Participating Provider. If you choose a dentist who participates in Delta Dental, your dentist will file your claim for you. If you use a Non-Participating Dentist, you will need to pay for services yourself and file a claim for reimbursement.

What's Covered

Your Dental Plan provides coverage for the following types of services:

- preventive and diagnostic
- basic restorative, and
- major restorative.

If you select the Premium Dental Plan, your children under age 19 will also be covered for orthodontic treatment.

Note: If you receive medical care benefits for a treatment through your Medical Plan, you may not receive benefits for the same treatment from your Dental Plan.

Preventive and Diagnostic Services

Preventive and diagnostic services are covered at 100% of the Maximum Plan Allowance without a deductible in both the Basic and Premium Dental Plans.

Preventive and diagnostic services include:

- oral examinations (evaluations), twice in any benefit period (includes all types);
- bitewing x-rays twice per year;

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- Periapical x-rays as needed;
- full-mouth x-rays, complete series or panoramic, once in any 36 consecutive months;
- a panoramic film with or without other films is considered equivalent to a full mouth series for coverage purposes (coverage for multiple radiographs on the same date of service will not exceed the coverage level for complete mouth series);
- dental prophylaxis (cleaning, scaling, and polishing) twice in any benefit period;
- periodontal maintenance visits, up to 4 visits per year (inclusive of 2 regular dental prophylaxis);
- topical fluoride application for dependent children under age 19, twice per benefit period;
- emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain);
- space maintainers that replace prematurely lost teeth of eligible dependent children under age 19; and
- sealants for dependent children under age 19, limited to caries-free occlusal surfaces of the first and second permanent molars, once in 5 years.

Basic Restorative Services

Basic restorative services are covered at 50% after your annual deductible in the Basic Dental Plan and are covered at 80% after your annual deductible in the Premium Dental Plan.

Basic restorative services include:

- restorative services using amalgam and composite filling material;
- periodontics: treatment for diseases of the gums and bone supporting the teeth;
 - periodontal surgery is covered only once in a 3-year period for the same site;
 - coverage for scaling and root planning are limited to once per 24 months;
- endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth);
- simple and surgical extractions; and
- general anesthesia in conjunction with covered surgical procedures.

Also, see the below *Basic Restorative Services Limitations* section for additional services that may not be covered under the Dental Plan.

Basic Restorative Service Limitations

The following limits apply to certain basic restorative services:

- endodontics (root canal treatment) on the same tooth is covered only once in a 24-month period (re-treatment of the same tooth is allowed when performed by a different dental office); and
- charges for replacement of filling restorations are only covered once in a 24-month period, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

Major Restorative Services

Major restorative services are covered at 50%, after your annual deductible under both dental plans.

Major restorative services covered under the Dental Plan include:

- prosthetics: bridges and dentures, once in five years;
- crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes, once in five years;
- oral surgery (except for extractions under the above *Basic Restorative Services* section); and
- implants, as well as bone-grafts, once in five years

Before receiving Basic or Major Restorative Services, you should seek a *Pretreatment Review* (described below) or ask your dental provider to seek it to ensure you know how much the Dental Plan estimates the Plan will cover. This allows you to understand how much the Plan will cover and how much may be your responsibility.

Also, see the below *Major Restorative Services Limitations* section for additional services that may not be covered under the Dental Plan.

Major Restorative Services Limitations

The following limits apply to certain major restorative services:

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- A replacement bridge or denture is covered under the Dental Plan once every five years if the existing bridge or denture cannot be satisfactorily repaired. You must be covered under the Dental Plan for at least one year before the Dental Plan will pay benefits for a replacement bridge or denture.
- A replacement crown, jacket, labial veneer, inlay or onlay is covered under the Dental Plan once every five years (except in the case of accidental injuries) if the existing crown, jacket, labial veneer, inlay or onlay cannot be satisfactorily repaired.
- Denture relines or rebasings are covered under the Dental Plan once every three years if they are performed six months after the initial replacement.
- A replacement implant is covered under the Dental Plan once every five years if the existing implant cannot be satisfactorily repaired. You must be covered under the Dental Plan for at least one year before the Dental Plan will pay benefits for a replacement implant.

Orthodontic Services (Premium Dental Plan only)

The Premium Dental Plan covers orthodontic services at 50% for children under age 19, after your annual deductible up to the lifetime maximum benefit of \$2,000 per child. Only children under age 19 are covered for treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position.

For new orthodontic treatment plans which began after the dependent child's effective date of coverage, the Dental Plan will consider up to 1/3 down of the total allowed treatment cost for the initial payment. Thereafter, at the end of each quarter, benefits will be provided for three months of fees. For orthodontic treatment cases which span six months or less, benefits will be provided in one payment based on the total allowed amount.

If your child is already in an orthodontic treatment dental plan prior to their effective date of coverage under the Edward Jones dental plan, benefits will begin with the first monthly payment after the dependent child's effective date of coverage under the Edward Jones dental plan. At the end of each quarter, benefits will be provided for three months of fees.

Payments will be made for the remaining scheduled balance of orthodontic costs, until the earlier of:

- The dependent's 19th birthday,
- The lifetime orthodontic maximum is reached,
- The end of the scheduled orthodontic treatment plan, or
- The dependent is no longer eligible for benefits.

Expenses incurred prior to your dependent child's benefits effective date are not eligible for payment under the Dental Plan.

Expenses incurred after termination of your dependent child's benefits are not eligible for payment under the Dental Plan (unless you continue participation via COBRA).

Pretreatment Review

If the cost estimate for a proposed dental service is more than \$200, your dentist may submit a treatment dental plan and a listing of proposed services and fees to Delta Dental before treatment begins. Delta Dental will then determine the benefits that will be payable for each dental service according to the terms of the Dental Plan and will notify your dentist of those benefits.

By following the pretreatment review process, you know how much the Dental Plan estimates the Plan will cover before the work is started and how much may be your responsibility. Benefit payment will be based on the benefits available when the services are rendered, and the claim is processed. This way you can make an informed decision about whether you want to proceed with certain services or whether you want to pursue other alternatives. You do not need to use the pretreatment review for emergency care.

Pretreatment review does not guarantee payment. Services must be covered by the Dental Plan. They also must be received while the patient is a Dental Plan participant.

Dental Plan Limits

See the below section labeled *What's Not Covered* for information about services not covered under the Edward Jones Dental Plan. Dental Plan limits include the following:

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Care from More Than One Dentist. If you receive care from more than one dentist for the same procedure, benefits will not exceed what would have been paid to one dentist for that procedure.

Dental Emergency. Treatment for the speedy relief of pain of a dental emergency will be covered as outlined under Preventive and Diagnostic Services. Additional dental services provided as follow-up care for the dental emergency, beyond the initial emergency visit, will be covered at the appropriate payment percentage level. If the additional services are likely to cost more than \$200, your dentist may submit a treatment dental plan to Delta Dental. See *Pretreatment Review*.

Alternative Treatment. If a lower cost alternative treatment is available, the Dental Plan will provide benefits for the least costly professionally satisfactory treatment. For example, if a patient receives fixed bridges the benefits may be based on the cost of a removable partial denture. If you and your dentist decide you want the more costly treatment, you are responsible for the charges above and beyond the benefits paid by the Dental Plan.

Coordination of Benefits. If you are eligible for benefits under another group dental plan, such as your spouse's dental plan, the Edward Jones Dental Plan will coordinate the benefit payments, so the combined payments do not exceed 100% of covered expenses. For example, if your spouse has dental coverage and he/she is also covered as a dependent under your Dental Plan, their dental plan will pay first and the Dental Plan will pay second, up to 100% of covered expenses, or the maximum allowed under the Dental Plan (whichever is less). For additional information on Coordination of Benefits, see the *Claim, Appeal and Legal Information* section of this SPD.

What's Not Covered

No benefits will be provided under the Dental Plan for:

- complete occlusal adjustments, crowns for occlusal corrections, nightguards, Bruxism appliances and Bite Therapy appliances,
- cosmetic services or to correct congenital malformations,
- denture adjustments for the first six months after initial receipt of the dentures,
- diseases contracted or injuries or conditions sustained as a result of any act of war, declared or undeclared, to the extent permitted under the Uniformed Services Employment and Reemployment Rights Act, as amended,
- duplicate services provided by another group dental or medical plan,
- duplication of radiographs,
- experimental or investigational services or supplies,
- hypnosis,
- infection control, including sterilization of supplies and equipment
- instructions in dental hygiene, dietary planning, or plaque control
- missed appointments or claim form completion
- multiple visits for services that start before the effective date including, but not limited to, prosthetics,
- analgesia, including nitrous oxide,
- periodontal splinting,
- replacement of lost or stolen dentures, retainers, or other dental appliances,
- separate fees for tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services which are part of a complete dental procedure and included in the fees for a complete dental procedure,
- services for which benefits are payable under workers' compensation or employers' liability law,
- services from a dental or medical department maintained by a mutual benefit association, labor union, trustee or similar person or group,
- services provided by dentists outside of the scope of their license,
- services provided by a state or federal government agency without cost,
- services that are not listed as covered services (including hospital or prescription drug charges),
- services where there would be no charge to you such as dental care a dentist provides for his or her immediate family,
- temporomandibular joint dysfunction (TMJ) services this involves the jaw hinge joint connecting the upper and lower jaws (TMJ services may be covered under the Edward Jones medical plan),
- temporary appliances, or

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- consultations.

For More Information

For more information regarding eligibility, COBRA continuation of coverage, administrative information about the Dental Plan (including filing claims and appeals) and your rights as a participant in the Edward D. Jones & Co. Employee Health & Welfare Program, please see the *Eligibility and Electing Benefits*, *Leaving the Plan*, and the *Claim, Appeal and Legal Information* sections respectively.