EDWARD D. JONES & CO. EMPLOYEE HEALTH AND WELFARE PROGRAM
FLEXIBLE SPENDING ACCOUNTS AND HEALTH SAVINGS ACCOUNTS
FREQUENTLY ASKED QUESTIONS

2026

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INTRODUCTION

Edward D. Jones & Co, L.P. ("Edward Jones") sponsors the Edward D. Jones & Co. Employee Health and Welfare Program ("Plan") as more fully described in the Plan Document and Summary Plan Description (the "SPD") available on Investing in You under resources or by submitting a General HR Inquiry on Gateway. The Plan is intended to qualify as a "cafeteria plan" within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended (the "Code"). An eligible associate can:

- Elect to reduce their salary to pay for the employee cost of medical, dental, vision and other elected coverage on a pre-tax basis (the "welfare plans").
- Make tax-free contributions to one or more of the following flexible spending accounts:
    - Health Flexible Spending Account ("Health FSA"),
    - Limited Purpose Health Flexible Spending Account ("LPFSA") for dental and vision expenses only,
    - Dependent Care Reimbursement Account ("DCRA"), and
- Make tax-free contributions to a Health Savings Account ("HSA")*.

Edward Jones may provide you annually with additional materials which describe each level of benefit related to a particular spending or savings account during the annual enrollment process or on the Edward Jones Investing In You website.

The official plan documents describe all the terms and conditions of the Edward Jones' benefit plans, and if there is any conflict or inconsistency between these materials and the terms of the official plan documents, the terms of the official plan documents will control. Edward Jones reserves the right to change, amend or terminate the benefit plans at any time, including, without limitation, amending the cost-sharing provisions of the Plan.

We have attempted to answer most of the questions you may have regarding the flexible spending accounts and also provided high level information about HSA*. If you have any questions regarding the terms of the Plan, please refer to the SPD or contact the Plan Administrator identified in the Plan Information Appendix.

If you have additional questions regarding the HSA, please contact HealthEquity at 844-281-0433.

**HSA is not an Edward Jones Sponsored benefit and is not an ERISA welfare plan.*

PART I: GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees and partners (referred to in these FAQs as "associates") to elect to reduce their salaries on a pre-tax basis to pay for the associate's share of premiums for the Plan (medical, dental, vision and long term disability) as well as make tax-free contributions to one or more of the flexible spending accounts (Health Flexible Spending Account ("Health FSA"), a Limited Purpose Health Flexible Spending Account ("LPFSA"), a Dependent Care Reimbursement Account ("DCRA")), or make pre-tax contributions to a Health Savings Account* ("HSA").

The Plan is beneficial to you because amounts that you elect to have withheld from your pay are withheld before any federal income and employment taxes (e.g., FICA and FUTA) are applied, and in most cases, before any applicable state taxes are applied. Participation in this Plan will actually increase your take home pay over what your net take home would be if you paid for such expenses with after-tax dollars.

This Plan is intended to comply with applicable provision of the Internal Revenue Code of 1986, as amended, ("Code"), including without limit Sections 125, and 223 of the Code.

Q-2. Who can participate in the Plan?

Generally you must be a regular full-time associate of Edward Jones or its designated affiliate to participate in the flexible spending accounts or contribute pre-tax to an HSA. As per applicable federal law, General Partners, Service Partners and Financial Advisors are eligible for some of the benefits as noted below.

Eligibility Chart:

Benefit	Minimum Scheduled Hours	Eligible
Medical, Dental, Vision	≥ 30 hours/week	Home Office Associate (HOA); Client Support Team professional (CST) ; General Partner (GP) (includes selling GP and subordinated limited partner); Service Partner (SP); Financial Advisor (FA) (includes Transitional Reps, interns, and trainees)
Health FSA	≥ 30 hours/week	HOA, CST, FA
Limited Purpose FSA (LPFSA)	≥ 30 hours/week	HOA, CST, FA Enrolled in the Anthem HDHP and contributing to an HSA
Dependent Care Reimbursement Account (DCRA)	≥ 35 hours/week	HOA, CST, FA
Health Savings Account (HSA)	≥ 30 hours/week	HOA; CST; GP; SP; FA Enrolled in the Anthem HDHP *Note: IRS eligibility requirements apply.*

In addition, any full-time associate living and temporarily working full-time for Edward Jones or its affiliates outside the U.S. is also eligible to participate if they remain on the U.S. Payroll.

You are not eligible to participate in the Plan if you are classified as a temporary employee or associate, contingent worker, independent contractor or otherwise not treated as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding obligation. Those eligible and enrolled in the Plan are called "Participants."

Q-3. How do I become a Participant?

To become a Participant, you must enroll within 30 days of your date of hire or the date you first become eligible to participate in the Plan. If you do not elect your benefits within that time frame, you will be deemed to waive all other benefits, except those that are fully company-paid. You may also enroll or make changes to your elections during the annual open enrollment period and within 30 days of a qualifying life event (for example, marriage, divorce or a birth of a child).

Enrollment is done through the Edward Jones Online Enrollment System. Additional information is communicated to you in the enrollment materials distributed to you.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until the earlier of the date that (i) you elect not to participate in the Plan; (ii) you no longer satisfy the eligibility requirements (e.g., you terminate employment, subject to COBRA); (iii) the Plan is terminated or amended to exclude you or the class of employees of which you are a member; or (iv) you are deemed to have waived participation in the Plan by failing to make an election into an FSA or HSA.

Q-5. Can I change my election during the Plan Year?

The "Plan Year" is the 12-month period beginning on January 1 and ending on December 31. You are not permitted to make changes to your benefit elections or Health FSA, LPFSA or DCRA contribution amounts until the next annual open enrollment period, unless you experience a qualifying life event as outlined below. However, if you are enrolled in the High-Deductible Health Plan (HDHP) option, you can generally make prospective election changes to your HSA at any time. You may change your benefit elections during the year if you or an eligible dependent experience a qualifying change in family or employment status (collectively referred to as a "qualifying life event"), as defined by the IRS and outlined below, which results in a loss or gain of coverage. If you experience a qualifying life event, you must initiate the request through Jones Associate Connection (JAC), or notify HRHELP at HRHELP@edwardjones.com, or by calling 1-800-440-3060 or 1-314-515-1006 within 30 days of the event (within 60 days if you or your eligible dependent lose eligibility under Medicaid or the Children's Health Insurance Program [CHIP]). Your new election must be consistent with the life event change and is effective on the date that of the life event. In the case of a child whom you are required to cover pursuant to a Qualified Medical Child Support Order (QMCSO), coverage will begin on the date specified in the order, or if

none is specified, the date of the order.

Qualifying life events include the following:

- You marry, divorce, legally separate, obtain an annulment, or end a relationship with a domestic partner;
- You register your domestic partnership or civil union under state or local law or the date you and your domestic partner meet the following requirements for six consecutive months:
    - Reside in the same household;
    - Be financially interdependent and jointly responsible for each other's common welfare;
    - Intend to remain in a committed relationship together; Both be at least 18 years of age;
    - Not be legally married to another person or in a domestic partnership with anyone else; and
    - Not be blood relatives.
- You have, adopt a child or gain legal custody of a child (including requirements pursuant to a Qualified Medical Child Support Order (QMCSO));
- Your dependent(s) dies;
- You or your dependent's employment status changes (e.g., moving from full-time to part-time employment or termination of employment);
- You or your spouse/domestic partner takes an unpaid leave of absence;
- You or your dependent's place of residence or worksite changes (you move in or out of a network area);
- Your child's dependent eligibility status changes; or
- There is a significant change in the benefits offered through your spouse's/domestic partner's Edward Jones (e.g., Edward Jones terminates the medical plan in which you are enrolled).

You may also change your election if you or your eligible dependents:

- Lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) because you are no longer eligible, or
- Become eligible for a state premium assistance subsidy under Medicaid or CHIP.

You may also change your DCRA elections if the cost of your dependent care provider has significantly increased or decreased.

Q-6. How long will the Plan remain in effect?

Although Edward Jones expects to maintain the Plan indefinitely, it has the right, within its sole discretion, to modify or terminate the Plan in whole or in part, at any time and for any reason, as it relates to any current, past or future participant or beneficiary. It is also possible that future changes in state or federal tax laws may require the Plan to be amended accordingly.

Q-7. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g. pension, disability and life insurance) that are based on taxable compensation.

PART II: HEALTH AND LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNTS

The following Questions and Answers relate to the Health Flexible Spending Account (FSA) and Limited Purpose Flexible Spending Account (LPFSA).

Q-8. What is the Health FSA?

The Health FSA allows you to set aside pre-tax money to pay for out-of-pocket medical, prescription, dental and vision expenses that are not reimbursed by any other means for you and your eligible dependents. To remain eligible to contribute to an HSA, you are not eligible for the Health FSA if you elect to participate in the high-deductible health plan ("HDHP).

Q-9. What is the LPFSA?

The LPFSA allows reimbursement of qualifying out-of-pocket dental and vision expenses. The LPFSA is only available to employees who enroll in the HDHP with a Health Savings Account (HSA). The LPFSA is designed to work together with an HSA to provide additional tax-saving opportunities and address regulatory limitations that don't permit participation in both a Health FSA and an HSA at the same time.

Q-10. How much can I contribute to the Health FSA or LPFSA?

You may contribute a minimum of $1 up to a maximum established and communicated each year, subject to IRS limitations. The maximum contribution is subject to increase annually by the IRS.

Q-11. How are amounts allocated to the Health FSA withheld from my pay?

Once you make your election during the annual enrollment process or when newly hired, an equal pro-rata portion of the annual contribution will be withheld from each paycheck in which benefit deductions are taken. If you make your election outside of the annual enrollment process, for example due to a qualifying life event, an equal pro-rate portion will be withheld from each paycheck remaining in the Plan Year.

Q-12. How do I receive reimbursement from the Health FSA or LPFSA?

When you elect to participate in one of the flexible spending accounts, you will automatically receive a debit card. This card can be used to pay for eligible expenses at the point of sale, avoiding out-of-pocket costs.

When you use your debit card, payments are automatically withdrawn from your flexible spending account. While most expenses can be validated through the debit card transaction, you may receive a request to provide a copy of the receipt in certain circumstances to substantiate your claim before you will be reimbursed. When required, receipts can be easily uploaded through the HealthEquity app, or on

https://my.Healthequity.com/ClientLogin.aspx. Reimbursements can be requested as often as eligible expenses are incurred (up to your maximum election).

Your claim can be completed through the HealthEquity app, on-line, or in such other manner as described on the HealthEquity website: https://my.Healthequity.com/ClientLogin.aspx. Reimbursement for expenses that are determined to be eligible expenses will be made as soon as administratively possible. You will receive notification if the expense is determined to not be an eligible expense.

Q-13. Is there a deadline by when Health FSA or LPFSA claims must be incurred and submitted?

Eligible expenses must be incurred by December 31 of the current Plan year, and the reimbursement must be requested before the claims filing deadline, which is March 31 of the following year. Any funds not used for eligible expenses by the end of the Plan year and submitted for reimbursement by March 31 of the following year are forfeited.

Q-14. What is an eligible expense under the Health FSA?

Typically, any medical care expense that would qualify as a deduction on your federal income tax return qualifies as an eligible expense under the Health FSA. An eligible expense is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "eligible dependent" is your legal spouse (in accordance with federal law) and generally any other individual who qualifies as your tax dependent for federal tax filing purposes under Section 152 of the Internal Revenue Code.

A list of eligible expenses can be found on HealthEquity's web site. You can also contact the IRS at 1-800-829-3676 and ask for IRS Publication 502, "Medical and Dental Expenses" or download the publication through the IRS web site at www.irs.gov.

The following is a partial list of eligible Health FSA expenses:

- Charges for medically necessary services not reimbursed by a medical, dental or vision plan, including:
  - Deductibles,
  - Out-of-pocket expenses (your coinsurance), Copayments,
  - Coinsurance (percentage of charges not paid by your health plan), Charges exceeding reasonable and customary amounts,
  - Charges exceeding plan limits, and
- Orthodontia expenses
- All medically necessary prescription drugs

- Eye exams, glasses (frames and lenses), contact lenses and solutions for contact lenses,
- Corrective laser eye surgery,
- Hearing exams and hearing aids,
- Smoking cessation programs,
- Cost differences between semi-private and private hospital rooms,
- Cosmetic surgery to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease,
- Costs for special medical equipment installed in your home, or for medical care home improvements (such as ramps, support bars or railings),
- Fees for special schools on the recommendation of a physician, including schools for the mentally impaired or physically disabled, or for individuals with severe learning disabilities,
- Transportation for and essential to medical care,
- Personal use items if primarily used to prevent or alleviate a physical or mental defect or illness (such as wigs, books, orthopedic shoes, or elastic hosiery), and
- Nursing services in a hospital, nursing home or your home.
- Other over-the-counter products such as:
- Band Aids
- Birth Control
- Braces & Supports
- Catheters
- Contact Lens Solution/Supplies
- Denture Adhesive
- Diagnostic Tests & Monitors
- Elastic Bandages & Wraps
- First Aid Supplies
- Insulin & Diabetic Supplies
- Ostomy Products
- Reading Glasses
- Wheelchairs, Walkers, & Canes

Q-15. Can I use my Health FSA for my domestic partner's medical, dental, or vision expenses?

Usually no. A Health FSA may reimburse eligible expenses for:

- you;
- your spouse;
- your tax dependents; and
- your child under age 27.

Because a domestic partner is not your spouse for federal tax purposes, your domestic partner's expenses are eligible for reimbursement only if your domestic partner qualifies as your tax dependent.

Q-16. Can I use my Health FSA for my domestic partner's child's medical, dental, or vision expenses?

Sometimes. A Health FSA may reimburse eligible medical expenses for your child who has not reached age 27 by the end of the tax year. Depending on the facts, a domestic partner's child may qualify if the child is treated as your qualifying child for federal tax purposes.

Q-17. What expenses are not eligible for reimbursement under the Health FSA?

A list of ineligible expenses can be found by visiting the HealthEquity website. You can also contact the IRS at 1-800-829-3676 and ask for IRS Publication 502, "Medical and Dental Expenses" or download the publication through the IRS web site at www.irs.gov.

The following is a partial list of expenses that may not be reimbursed through the Health FSA:

- Contributions to other Edward Jones-sponsored medical or dental plans,
- Costs you deduct as medical care expenses on your federal income tax return,
- Expenses not eligible to be deducted from your federal income tax return,
- Expenses reimbursed by any other health plan,
- Over-the-counter drugs and medicines, such as pain relievers and allergy medicines, that have not been prescribed by a physician,
- Health club membership dues,
- Cosmetic surgery,
- Electrolysis, hair removal or transplants,
- Prescription drugs that are not medically necessary (such as Rogaine or Retin-A),
- Cosmetic dental work (including bleaching, bonding and veneers),
- Diaper services (unless required to relieve the effects of a medical condition),
- Undocumented travel to or from your physician's office or other medical facility,
- Weight loss programs unless it's for the treatment of a medical condition (letter of medical necessity required)
- Long-term care services,
- All premiums for insurance coverage (including health insurance, long-term care, loss of income and loss of life), and
- Funeral expenses.

Q-18. What are eligible vision and dental expenses under the LPFSA?

Eligible expenses under the LPFSA are similar to those for the Health FSA as outlined below with the exception that you can **only** receive reimbursement of eligible dental and vision expenses incurred by you or your eligible dependents.

Q-19. What happens if I have money remaining in my Health FSA or LPFSA at the end of the Plan year?

The Health FSA and LPFSA are use it or lose it, meaning you must incur eligible expenses by December 31 of the Plan year, and submit for reimbursement by March 31 of the following Plan year. **Any funds not used for eligible expenses by the end of the year and submitted for reimbursement by March 31 of the following year are forfeited.**

Q-20. Does the Health FSA or Limited Purpose FSA have a grace period or carryover?

No. The Health FSA and LPFSA do not offer a grace period or a carryover feature. As noted above, any funds not used for eligible expenses by the end of the year and submitted for reimbursement by March 31 of the following year are forfeited.

PART III: DCRA BENEFITS

The following Questions and Answers relate to the Dependent Care Reimbursement Account (DCRA).

Q-21. What is the DCRA?

The DCRA allows you to set aside pre-tax money to help you pay for eligible dependent care expenses that enable you (and your spouse if you are married) to work or actively look for paid work. Dependent care expenses may also qualify if your spouse is disabled or a full-time student.

Note: Dependent care expenses are only reimbursable from DCRA while you are working. Any leave longer than two weeks makes dependent care expenses generally ineligible for reimbursement except for short-term absences of up to two consecutive weeks.

Q-22. What is the maximum reimbursement amount that I may elect under the DCRA?

You may contribute a minimum of $1 up to a maximum amount established and communicated each year, subject to IRS limitations. The following IRS rules governing DCRAs may reduce the maximum amount you can contribute to the DCRA. You should consult with your tax advisor and refer to IRS Publication 503 for additional information.

- If you and your spouse file a joint tax return, the most your family can contribute to a DCRA in one year is the IRS maximum. That means if your spouse's employer also offers a DCRA, the combined total you contribute to both plans cannot exceed the maximum contribution amount established by the IRS for the year (subject to the minimum income limit, see below). Otherwise, you may be required to pay interest and penalties.

- If you are married and filing separate income tax returns, the most you can contribute to the DCRA is one-half (1/2) of the IRS maximum contribution limit for the year.

- You cannot contribute more to the DCRA than the amount of income you earn during the year, or the amount your spouse earns if you are married, whichever is less. For this purpose, the IRS defines income as compensation before taxes, excluding any salary amounts contributed to a DCRA. For example, if you make $30,000 and your spouse makes $3,000, the maximum you can contribute to a DCRA is $3,000. Please consult with your tax advisor for complete information on income and contribution considerations.

- If you were enrolled in a DCRA with a previous employer in the same year, you can only elect up to an amount that will not exceed the IRS maximum for the year if married and filing separate income tax returns.

Please consult with your tax advisor for complete information on income and contribution considerations specific to your own situation.

Q-23. What amounts will be available for reimbursement of eligible daycare expenses at any particular time during the Plan Year?

Under the DCRA, you may be reimbursed only up to the amount of your DCRA account balance at the time the request for reimbursement is processed.

Q-24. Can I use my DCRA for reimbursement of my domestic partner's child's dependent care expenses?

Maybe. In general, the child must be under age 13 when the care is provided and must be your qualifying child under the federal tax rules.

Q-25. How do I receive reimbursement under the DCRA?

DCRA claims can be set up on recurring payments. Claim forms are available on the HealthEquity website. When submitting the completed form on the HealthEquity website, you must also include an itemized receipt of the monthly amount paid, or the care provider can sign the claim form. A claim will be entered for your total election amount and Health Equity will prorate and send automatic payments up to the election amount at the end of each month until the funds have been exhausted.

Q-26. What expenses are eligible for reimbursement under the DCRA?

To qualify for reimbursement from the DCRA, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Under the law, a "dependent" for purposes of the Dependent Care Reimbursement Account is:

- Your dependent child who:
  - Is under age 13
  - Lives with you for more than 6 months during the year
  - You can claim as a dependent on your tax return

OR

- Your spouse or other tax dependent who:
  - Lives with you for more than 6 months during the year, and
  - Is physically or mentally unable to care for themself

If the care is provided outside your home, your dependent must spend at least eight hours a day in your home.

A list of eligible expenses can be found by visiting the HealthEquity website. You can also contact the IRS at 1-800-829-3676 and ask for IRS Publication 503, "Child and Dependent Care Expenses" or download the publication through the IRS web site at www.irs. gov.

The following is a partial list of eligible DCRA expenses:

- Care at licensed nursery schools, or day camps (not overnight camps). To qualify,

the school or center must comply with state and local laws and receive a fee for its services if it cares for seven or more children,
- Care provided by an individual service provider (the individual service provider will need to give you their Social Security Number and they will have to declare any monies that you pay them from your DCRA as taxable income up to $7,500 per year),
- Care provided at an adult day care facility (but not expenses for an overnight, nursing home facility),
- Care provided before-school or after-school,
- Payroll taxes on behalf of an eligible dependent care service provider,
- Care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under the age of 19, and
- Household services related to the care of eligible dependents who live with you.

Q-27. What expenses are not eligible for reimbursement under the DCRA?

A list of ineligible expenses can be found by visiting the HealthEquity website. You can also contact the IRS at 1-800-829-3676 and ask for IRS Publication 503, "Child and Dependent Care Expenses" or download the publication through the IRS web site at www.irs.gov.

The following is a partial list of expenses that do not qualify for reimbursement through the DCRA:

- Expenses incurred after a dependent is no longer eligible,
- Food, clothing, education, and entertainment,
- The cost of transportation to or from the place where day care services are provided,
- Expenses you claim as deductions on your federal income tax return or that you use to take the federal dependent care tax credit,
- Expenses not eligible for deduction on your federal income tax return,
- Evening babysitting expenses (unless both parents, if married, work during the evening),
- Overnight camp,
- Boarding school,
- Care provided by your spouse, children under age 19 or by any dependent you claim on your federal tax return, and
- Expenses for a non-working spouse who is neither disabled nor a full-time student

Q-28. Is there a deadline in which DCRA claims must be incurred and submitted?

Eligible expenses must be incurred ***during*** the Plan Year and while a Participant. An expense is "incurred" when the service giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the DCRA becomes effective, before your DCRA election becomes effective, or after a separation from service.

Eligible expenses must be submitted for reimbursement by the annual claim filing deadline (i.e., March 31 of the year following the year for which the election was made).

Any funds not used for eligible expenses by the end of the year and submitted for reimbursement by March 31 of the following year are forfeited.

Q-29. Does the DCRA have a grace period or a carryover?

No. The DCRA cannot offer a carryover under IRS rules, and the DCRA does not provide a grace period. As noted above, any funds not used for eligible expenses by the end of the year and submitted for reimbursement by March 31 of the following year are forfeited.

Q-30. Will I be taxed on the DCRA reimbursement I receive?

You will not normally be taxed on your DCRA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this DCRA and/or another employer's DCRA) does not exceed the statutory limits set forth by the IRS. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. You should consult with a tax advisor if you have any questions about the tax implications.

PART IV: HEALTH SAVINGS ACCOUNT*

The following Questions and Answers relate to the Health Savings Account (HSA).

Q-31. What is the Health Savings Account (HSA)?

The HSA is a tax-advantaged savings account that you own and can contribute to on a pre-tax basis. You can use the funds in your account to pay for qualified medical expenses.

Generally, you are eligible to contribute to an HSA if you are enrolled in the high-deductible health plan ("HDHP") and have established an HSA with a qualified third-party custodian. The custodian for pre-tax payroll contributions and any Edward Jones contributions is HealthEquity.

Any funds remaining in the HSA at the end of the calendar year (December 31) are rolled over to the following year. In addition, an HSA is portable. This means that if you change employers or leave the workforce, the HSA remains with you.

Q-32. Are my HSA contributions and earnings taxable?

Generally, your contributions and earnings are tax-free for federal purposes. When you contribute through payroll, the amount is not subject to federal income tax or FICA (Social Security and Medicare) taxes, and your HSA earnings are not subject to federal income tax. State tax treatment of HSAs varies, and a few states tax HSA contributions or earnings, so please check with your tax advisor to understand how your state treats HSAs.

If you set up your HSA with a custodian other than HealthEquity, you contribute from your own already-taxed funds (not through payroll) and claim a corresponding deduction on your tax return. In that case, you still get the income tax benefit, but you do not get the FICA savings, and you will not receive an employer contribution.

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Q-33. Who is eligible for an HSA?

Per IRS guidelines, an account holder must be enrolled in a HDHP. In addition:

- You can't be covered by another non-HDHP plan, such as a spouse's plan, that provides benefits covered by the HDHP.
- You or your spouse can't have a Health Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) in the same year, unless the FSA or HRA is specially designed to work with an HSA; e.g., a Limited Purpose FSA.
- You can't be enrolled in Medicare or TRICARE.
- You can't have used Veterans Affairs (VA) medical benefits in the prior three months, except in cases where the hospital care or medical services were for a service-connected disability.
- You can't be claimed as a dependent on another person's tax return.

Q-34. What expenses are qualified medical expenses eligible for tax-free distributions from my HSA?

In general, "qualified medical expenses" means amounts paid for "medical care" (as defined in Code section 213(d)) for the individual, the spouse of the individual, and any dependent of the individual, but only to the extent the amounts are not compensated for by insurance or otherwise. Please speak with your tax advisor or review IRS Publication 969 for further details.

Q-35. Can I use my HSA for my domestic partner's medical, dental, or vision expenses?

Usually, no**.** HSA funds generally may be used tax-free only for your own qualified medical expenses, your spouse's, and your eligible tax dependents'. A domestic partner's expenses generally are not eligible unless the domestic partner qualifies as your tax dependent under federal tax rules. State tax rules may vary. Please consult with your tax advisor.

Q-36. I have an HSA from a previous employer; can I also contribute to an HSA through Edward Jones?

Yes. You can have more than one HSA. The amount that you contribute to all HSAs each year is limited to the annual contribution limit established by the IRS for the year. You may also close your old HSA and transfer the funds to your HSA with HealthEquity.

Q-37. If I am no longer enrolled in the HDHP, can I still use funds in my HSA to pay for health care expenses?

Yes, you can continue to use your HSA funds to pay for qualified out-of-pocket health care expenses.

Q-38. If l am no longer enrolled in the HDHP, can I still make contributions to my HSA?

You cannot earn new HSA contribution room for any month in which you are not covered by a qualified HDHP. However, you can still deposit contributions for the months in which you were eligible, and you generally have until the tax filing deadline to do so (typically April 15 of the following year), even if you are no longer covered by the HDHP by the time you make the deposit. In short, losing HDHP coverage stops you from being eligible to make future contributions, but it does not eliminate the room you already have from the months you were eligible.

Q-39. When will funds in my HSA be available for use?

If you enroll in the HDHP, your contributions will commence within 1 - 2 pay periods from the date your HSA is established. You can start using the funds in your HSA for qualified medical expenses that you incur on or after the HSA effective date. You cannot use the HSA for medical expenses that you incurred before the HSA effective date.

Note that Edward Jones may contribute to your HSA and will communicate such contribution during Open Enrollment.

Q-40. How much can I contribute to my HSA?

The maximum amount you can contribute to an HSA is set by the IRS. The annual limit available to contribute through payroll deductions (up to the IRS maximum) will be communicated during Open Enrollment each year. If you are age 55 or older, you can contribute another $1,000 per year. This is a "catch-up" contribution designed to allow additional savings for retirement medical expenses. If both you and your spouse are 55 or older, each of you must make your own catch-up contribution to your own HSA. A married couple cannot combine both catch-up amounts in a single account. Amounts are subject to annual changes by the IRS.

Q-41. How much can I contribute if I am not enrolled in the HDHP for the entire year? What if I make a change to my medical coverage mid-year?

Your contribution limit is figured month by month rather than as a single annual number. For each month, your HSA eligibility and your medical coverage tier are determined as of the first day of that month, and you earn one-twelfth of the IRS annual limit for whatever medical plan coverage tier (e.g., single or family) you maintain. Your maximum contribution limit is the sum of those monthly amounts.

This matters in two important situations:

1. *If you change medical coverage mid-year*. For example, if you have family coverage for part of the year and single coverage for the rest of the year, your contribution limit amounts are blended to account for the change. You get the family contribution limits for the family medical coverage months and the single contribution limits for the single medical coverage months, added together.

2. *If you become newly eligible and join the HDHP mid-year*. If you become HSA-eligible on December 1, the IRS permits you to contribute the full annual maximum for that year as if you had been covered for all twelve months. There is a condition: you must remain HSA-eligible through December 31 of the following year. If you lose eligibility before then, not due to death or disability (for example, you drop HDHP coverage), the extra amount you contributed above the month-by-month limit is included in your income and subject to an additional 10% tax. Using the “last month” rule is optional, so if you would rather not take on that condition, you can simply contribute the month-by-month amount instead.

These rules are complicated. Please speak with your tax advisor or review IRS Publication 969 for details on your specific situation.

Q-42. I became eligible for Medicare during the year; can I continue to contribute to my HSA?

If you are eligible for Medicare benefits but didn't enroll in Medicare, you can still contribute to your HSA.

If you enroll in Medicare, you can no longer make contributions to your HSA beginning with the first month you are covered by Medicare. This rule applies even if you are automatically enrolled in Medicare Part A coverage. In this situation, you would need to prorate the amount you are allowed to contribute for the tax year based on the number of months you're not covered by Medicare.

Note: Medicare Part A can be retroactive up to six months from your enrollment date (but not before your 65th birthday). If you contributed to your HSA during those months, you may have made impermissible contributions and could face penalty taxes. To avoid excess contributions, it's recommended to stop HSA contributions at least six months prior to your anticipated Medicare start date.

Q-43. How do I receive reimbursement under the HSA?

You are eligible to receive reimbursements from your HSA after you have incurred an eligible expense. Eligible expenses are the same as outlined above for the Health FSA (Q-15) and may be reimbursed to you on a tax-favored basis. You can submit for reimbursements from your HSA through HealthEquity, the HSA custodian. Edward Jones is not involved in this process and has no relationship with HealthEquity other than forwarding your pre-tax elections to your HSA. If you have any questions about the HSA you should contact HealthEquity. If you use your HSA funds for a non-qualified expense, you will have to pay income taxes on that amount. You may also have to pay a 20% penalty tax. Tax rules are complicated, so we recommend you consult with your tax advisor and/or refer to IRS Publication 969 regarding the tax implications associated with an HSA.

Q-44. Do I need to keep my receipts?

Yes, you should keep all receipts, as they will show you used your HSA funds for qualified health care expenses. You will need them if the IRS ever audits your tax return.

Q-45. When can I receive distributions from my HSA?

Once you have funds in your HSA, you can use the funds at any time. You can keep the funds there to save for future expenses or you can use the funds to pay for expenses you now have. You cannot use funds for expenses incurred prior to your HSA effective date.

Q-46. Do I receive a debit card for my HSA?

Yes. Once your HSA is opened, you will receive a debit card from HealthEquity.

Q-47. What happens to my HSA if I leave Edward Jones or I cancel my health plan coverage?

If you leave Edward Jones or cancel your health plan coverage, the HSA account stays with you, and you may continue to use your remaining balance for eligible health care expenses.

PART V: PLAN ADMINISTRATION

Q-48. What happens if a claim for benefits under the Health FSA, LPFSA or DCRA is denied?

If you are denied a benefit under the Health FSA, LPFSA or DCRA, you will receive a denial notice. The claims review procedures are as follows:

Step 1: *Notice received from Health Equity, the Third Party Administrator.* If your claim is denied, you will receive written notice from Health Equity that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of Health Equity, Health Equity may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which Health Equity must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from Health Equity, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: If *you disagree with the decision, file an appeal.* If you do not agree with Health Equity's decision, you may file a written appeal. You should file your appeal with Health Equity no later than 180 days after receiving the notice described in Step **1.** You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial received from HealthEquity.* If the claim is again denied, you will be notified in writing no later than 60 days after receipt of the appeal by HealthEquity. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Your appeal will be independent from the claims determination (i.e., the same person(s) or subordinates of the same person(s) involved in the claim determination would not be involved in the appeal).
- On appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give you notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision. You have one year from the date of the final appeals denial notice to file a suit.
- You have the right to request and obtain documents, records and other information as it pertains to your claim.

Q-49. What is COBRA continuation and how does it apply to the Flexible Spending Accounts and HSA?

The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") is a federal law which allows you or your enrolled dependents to continue coverage under a group health plan after a "qualifying event" occurs. A qualifying event is an event which would cause you or your enrolled dependents to lose health coverage under the terms of the Plan. Qualifying events may include your death, your termination of employment or reduction of hours, transfer to service partner, your divorce or legal separation, your entitlement to Medicare, or a dependent child's loss of dependent status. Please review the SPD available on Investing in You under Resources for complete details regarding COBRA.

COBRA applies to the Health FSA and LPFSA, but does not apply to the DCRA or HSA. Flexible spending account benefits are considered a separate group health plan and special COBRA rules apply. COBRA is limited to the qualifying events of ‘termination of employment’ and ‘reduction on hours’. Under the COBRA regulations, COBRA will apply for the remainder of the Plan Year if you have "underspent" your Health FSA or LPFSA when the qualifying event occurs. "Underspent" means that when the qualifying event occurs, your unused benefits are greater than the COBRA amounts that you will be required to pay to continue the benefits under COBRA for the remainder of the Plan year.

The COBRA Administrator will tell you how long you may continue coverage under COBRA and will provide you a COBRA Election Form. You may elect COBRA coverage as provided on the form.

Q-50. Will my Health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Health FSA and LPFSA and the third-party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate privacy notice that outlines the Edward Jones's HIPAA privacy policies.

In addition, the U.S. Department of Labor has issued cybersecurity tips on keeping your personal information secure. You can reduce the risk of fraud and loss to your data and health information by following these basic rules:

- **Set up and routinely monitor your online account**
  - Regularly check your claims online to reduce the risk of fraudulent account access.
  - Failing to register for an online account may enable cybercriminals to assume your online identity.
- **Use strong and unique passwords**
  - Do not use dictionary words.
  - Use letters (both upper and lower case), numbers, and special characters.
  - Do not use letters and numbers in sequence (no "abc," "567," etc.).
  - Use 14 or more characters.
  - Do not write passwords down.
  - Consider using a secure password manager to help create and track passwords.
  - Change passwords every 120 days, of it there's a security breach.
  - Do not share, reuse, or repeat passwords.
- **Use multi-factor authentication**
  - Multi-factor authentication (also called two-factor authentication) requires a second credential to verify your identity (for example, entering a code sent in real-time by text message or emails).
- **Keep personal contact information current**
  - Update your contact information when it changes, so you can be reached if there is a problem.
  - Select multiple communication options.
- **Close or delete unused accounts**
  - The smaller your on-line presence, the more secure your information. Close unused accounts to minimize your vulnerability.
  - Sign up for account activity notifications.
- **Be wary of free Wi-Fi**
  - Free Wi-Fi networks, such as the public Wi-Fi available at airports, hotels, or coffee shops pose security risks that may give criminals access to your personal information.
  - A better option is to use your cellphone or your home network.
- **Be aware of phishing attacks**
  - Phishing attacks aim to trick you into sharing your passwords, account numbers, and sensitive information, and gain access to your accounts. A phishing message may look like it comes from a trusted organization, to lure you to click on a dangerous link or pass along confidential information.
  - Common warning signs of phishing attacks include:

        - A text message or email that you did not expect or that comes from a person or service you do not know or use.
        - Spelling errors or poor grammar.
        - Mismatched links (a seemingly legitimate link sends you to an unexpected address). Often, but not always, you can spot this by hovering your mouse over the link without clicking on it, so that your browser displays the actual destination.
        - Shortened or odd links or addresses.
        - An email request for your account number or personal information (legitimate providers should never send you emails or texts asking for your password, account number, personal information, or answers to security questions).
        - Offers or messages that seem too good to be true, express great urgency, or are aggressive and scary.
        - Strange or mismatched sender addresses.
        - Anything else that makes you feel uneasy.
- **Use antivirus software and keep apps and software current.**
    - Make sure that you have trustworthy antivirus software installed and updated to protect your computers and mobile devices from viruses and malware. Keep all your software up to date with the latest patches and upgrades. Many vendors offer automatic updates.
- **Know how to report identity theft and cybersecurity incidents.**
    - The FBI and the Department of Homeland Security have set up valuable sites for reporting cybersecurity incidents:
        - https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view
        - https://www .cisa.gov/reporting-cyber-incidents

Q-51. How do Nondiscrimination rules applicable to DCRA impact the administration of contributions?

The DCRA must not discriminate in favor of "highly compensated employees" (HCEs), as that term is defined in the Internal Revenue Code (IRC), with respect to eligibility, benefits or Edward Jones contributions. If the operation of this Plan violates any IRC nondiscrimination rule, the Plan Administrator has the right to unilaterally and/or retroactively modify elections of HCEs, place limitations on the HCEs' pre-tax salary reduction contributions, and modify HCE benefit selection, availability and/or the method of allocating the HCEs' pre-tax contributions in order for the Plan to meet the nondiscrimination requirements. Any changes in the rate of pre-tax contributions of any HCE will be applied in a fair and consistent manner.