

EDWARD D. JONES & CO. EMPLOYEE HEALTH AND WELFARE PROGRAM
FLEXIBLE SPENDING ACCOUNTS
SUMMARY PLAN DESCRIPTION

Effective January 1, 2024

THE PLAN AS OUTLINED IN THIS SUMMARY PLAN DESCRIPTION IS GOVERNED IN EVERY RESPECT BY THE WORDING OF THE ACTUAL PLAN, WHICH IS AVAILABLE FOR INSPECTION BY ALL PLAN PARTICIPANTS. IN THE EVENT OF ANY CONFLICT, THE PLAN SHALL PREVAIL. THE PLAN IS SUBJECT TO CHANGE IN ACCORDANCE WITH THE PROVISIONS OF THE PLAN AND APPLICABLE LAWS. ANY MATERIAL CHANGES TO THE PROVISIONS OF THIS DOCUMENT WILL BE COMMUNICATED TO PARTICIPANTS.

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**EDWARD D. JONES & CO. EMPLOYEE HEALTH AND WELFARE PROGRAM
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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”) to allow eligible employees to elect to reduce their salaries to pay for the employee cost of healthcare, dental, vision and other coverages on a pre-tax basis as well as tax-free contributions to one or more of the following accounts: a Healthcare Care Flexible Spending Account (“HCFSA”), a Limited Purpose Healthcare Flexible Spending Account (“LPFSA”), a Dependent Care Flexible Spending Account (“DCFSA”), and 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 document is a summary of the provisions of the Plan, as amended, and is referred to as the Summary Plan Description (“SPD”), and supersedes any prior versions of the SPD. In addition to this SPD, 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 Benefits Center website. These additional underlying materials are incorporated as part of this SPD.

This SPD describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. This SPD describes the Plan’s benefits and obligations as contained in the legal plan document for the Edward Jones Benefits Plan, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal plan document, please contact the Plan Administrator identified in the Plan Information Appendix.

We have attempted to answer most of the questions you may have regarding your benefits in this SPD. If you have any questions regarding the terms of the Plan, the Healthcare FSA, LPFSA, DCFSA, and/or the HSA, contact the Plan Administrator identified in the Plan Information Appendix. The Plan Administrator’s name, address and telephone number appear in the Plan

*Effective March 1, 2025, an HSA is not an Edward Jones Sponsored benefit and is not an ERISA welfare plan.

Information Appendix at the end of this SPD. Other important information has also been provided in the Plan Information Appendix attached to this SPD.

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 to elect to reduce their salaries to pay for the employee cost of medical, dental, vision and long term disability on a pre-tax basis as well as make tax-free contributions to one or more of the following accounts: a Healthcare Flexible Spending Account (“HCFSA”), a Limited Purpose Healthcare Flexible Spending Account (“LPFSA”), a Dependent Care Flexible Spending Account (“DCFSA”), and 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, 223 and 132(f) of the Code.

Q-2. Who can participant in the Plan?

To be eligible under the HCFSA, LPFSA or the HSA you must be a regular full-time employee of the Employer who is scheduled to work at least 30 hours per week. To be eligible under the DCFSA you must be regular full-time employee of the Employer working at least 35 hours per week and one of the following type of employees: (1) Home Office Associate (HOA) or Branch Office Associate (BOA)), which includes Transitional Representatives (TR), Assistant Financial Advisors and Financial Advisor Career Development (FACD) Associates; (2) General Partners (GP), which includes subordinated limited partners or Service Partners (SP); or (3) Financial Advisors (FA), which includes selling general partners, financial advisor interns and trainees. 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.

The term “Employer” refers to Edward Jones and any company related to Edward Jones which has adopted the Plan, which company is referred to as an “Affiliate.” You are not eligible to participate in the Plan if you are classified as a temporary employee, 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 employees who actually participate in the Plan are called “Participants.”

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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 Benefits website 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 HCFSA, LPFSA or DCFSA 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 Consumer Driven Health Plan (CDHP) you can generally make any prospective election changes to your HSA at any time. Participants who enroll in the CDHP who have a HCFSA balance remaining at the end of the prior Plan Year, will automatically have their HCFSA balance, up to \$640 (for 2024), transferred to a LPFSA and available for reimbursement of eligible dental and vision care expenses.

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 log onto the Edward Jones benefits website to process the change or notify the HR Help Desk at 1-800-440-360 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 employer (e.g., the employer 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 DCFSA 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: HEALTHCARE AND LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNTS

The following Questions and Answers relate to the HCFSA and LPFSA.

Q-8. What is the HCFSA?

The HCFSA 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 health insurance plan for you and your eligible dependents. Due to IRS regulations, you are not eligible for the HCFSA 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 who have an HCFSA balance remaining at the end of the Plan Year. Such employees will automatically have their HCFSA balance, up to \$640 (for 2024), transferred to a LPFSA and available for reimbursement of eligible dental and vision care expenses. 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 HCFSA and an HSA at the same time.

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

You may contribute a minimum of \$1 up to a maximum of \$3,050 to the HCFSA in 2024. The maximum contribution is subject to increase annually by the IRS. The maximum that can be automatically transferred from the HCFSA to the LPFSA for employees enrolled in the HDHP is \$640 (for 2024).

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

Once you make your election during the annual enrollment process, an equal pro-rata portion of the annual contribution will be withheld from each paycheck. 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 HCFSA or LPFSA?

When you elect to participate in a Flexible Spending Account, you will automatically receive a debit card. This is a credit card that works as a debit card and allows you 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 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 onto <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 on-line or in such other manner as described on the Health Equity 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 HCFSA or LPFSA claims must be incurred and submitted?

Eligible expenses must be incurred during the Plan Year and the reimbursement must be requested before the claims filing deadline which is March 31st of the following year.

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

Typically, any health care expense that would qualify as a deduction on your federal income tax return qualifies as an eligible expense under the HCFSA. 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 by visiting the Edward Jones Benefits web site, clicking on “Resources” and selecting “HCFSA Eligible Expenses” under “Spending Accounts.” 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 Care 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. What expenses are not eligible for reimbursement under the HCFSA?

A list of ineligible expenses can be found by visiting the Health Equity [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 expenses that may not be reimbursed through the HCFSA:

- Contributions to other employer-sponsored medical or dental plans,
- Costs you deduct as health 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-16. What are eligible medical expenses under the LPFSA?

Eligible medical expenses under the LPFSA are similar to those for the HCFSA 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-17. What happens if I have money remaining in my HCFSA or LPFSA?

The HCFSA and LPFSA have a carryover provision. This means that if you have an account balance at the end of the Plan Year, up to \$640 (for 2024) can be carried over into the following Plan Year to be used for claims incurred in the following Plan Year. Any amount remaining in the HCFSA or LPFSA in excess of \$640 (for 2024) will be forfeited if not used for claims incurred in the current Plan Year and submitted for reimbursement by the claims filing deadline which is on June 30th of the following Plan Year.

If you have a balance at the end of a Plan Year in your HCFSA and you elect to participate in the HDHP for the following Plan Year, any carryover dollars (up to \$640, for 2024) will automatically be transferred to the LPFSA and can be used to reimburse eligible dental and vision care expenses incurred in the following Plan Year.

PART III: DCFSA BENEFITS

The following Questions and Answers relate to the DCFSA.

Q-18. What is the DCFSA?

The Dependent Care Flexible Spending Account 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. You may also qualify if your spouse is disabled or a full-time student.

Q-19. What is the maximum reimbursement amount that I may elect under the DCFSA?

You may contribute a minimum of \$1 up to a maximum of \$5,000 to the DCFSA, subject to IRS limitations. The following IRS rules governing DCFSAs may reduce the maximum amount you can contribute to the DCFSA. 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 DCFSA in one year is \$5,000. That means if your spouse's employer also offers a DCFSA, the combined total you contribute to both plans cannot exceed \$5,000 (subject to the minimum income limit, see below). For example, if your spouse contributes \$3,000, the maximum you can contribute is \$2,000. 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 DCFSA is \$2,500,
- You cannot contribute more to the DCFSA 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 DCFSA.) For example, if you make \$30,000 and your spouse makes \$3,000, the maximum you can contribute to an FSA is \$3,000, and
- If your spouse is a full-time student for at least five months of the year or is disabled, the law considers your spouse's income to be at least \$250 a month if you have one dependent or \$500 a month if you have two or more dependents.

If you were enrolled in a DCFSA with a previous employer in the same year, you can only elect up to an amount that will not exceed \$5,000 for the year or \$2,500 for the year if married and filing separate income tax returns.

Q-20. What amounts will be available for reimbursement of Eligible Day Care Expenses at any particular time during the Plan Year?

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

Q-21. How do I receive reimbursement under the DCFSA?

When you elect to participate in a Flexible Spending Account, you will automatically receive a debit card. This is a credit card that works as a debit card and allows you 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 account and you must submit written statement from the service provider (e.g., an invoice) associated with each expense to the Health Equity website (<https://my.healthequity.com/ClientLogin.aspx>) that indicates the following:

- The nature of the expense;

- The date or dates the services were provided; and
- The amount of the expense.

Your claim can be completed on-line or in such other manner as may be described on the Health Equity website. 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-22. What expenses are eligible for reimbursement under the DCFSA?

To qualify for reimbursement from the DCFSA, 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 Flexible Spending Account is:

- Your child, grandchild, sibling, or descendant of any of the above who:
 - Is under age 13
 - Lives with you for more than 6 months during the year
 - Does not provide over half of his/her own support during the year

OR

- Your spouse, parent, child, sibling, aunt, uncle, or any other individual who:
 - Lives with you for more than 6 months during the year
 - Is physically or mentally unable to care for himself/herself or any other person of any age who is physically or mentally incapable of self-care whom you are entitled to claim as a dependent on your federal tax return.

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 Edward Jones Benefits web site, clicking on “Resources” and selecting “DCFSA Eligible Expenses” under “Spending Accounts.” 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 Dependent Care FSA 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 Dependent Care FSA as taxable income up to \$5,000 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-23. What expenses are not eligible for reimbursement under the DCFSA?

A list of ineligible expenses can be found by visiting the Health Equity [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 DCFSA:

- 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-24. Is there a deadline by when DCFSA 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 DCFSA becomes effective, before your DCFSA 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 filing deadline will be forfeited.

Q-25. Will I be taxed on the DCFSA reimbursement I receive?

You will not normally be taxed on your DCFSA reimbursement, provided that your family’s aggregate dependent day care reimbursement (under this DCFSA and/or another employer’s DCFSA) does not exceed the statutory limits set forth above. 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.

Q-26. What is the Health Savings Account?

The HSA is tax-advantaged savings account that you own and are able to contribute to on a pre-tax basis. You can use the funds in your account to pay for qualified health expenses. You are eligible to contribute to an HSA if you are enrolled in the high deductible health plan (“HDHP”) to contribute to an HSA an account that you established with a third party custodian.

Any funds remaining in the HSA at the end of the plan year (i.e. 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 work force, the HSA remains with you.

Q-27. Are my HSA contributions and earnings taxable?

Generally, your contributions and earnings are tax-free. This means you don't pay federal taxes on the amount you contribute from your paycheck to your HSA (the custodian offered by Edward Jones is Health Equity.). In addition, your HSA earnings aren't subject to federal income tax. If you set up your HSA with a bank other than Health Equity, you will have to contribute from your

*Effective March 1, 2025, an HSA is not an Edward Jones Sponsored benefit and is not an ERISA welfare plan.

own funds (not via payroll deduction) and then claim a corresponding deduction on your tax return. In addition, you will not receive the employer contributions.

Q-28. 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 care 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; i.e. 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-29. 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 in a given year is limited to the annual contribution limit for the year. You may also close your old HSA and transfer the funds to your new HSA with Health Equity.

Q-30. 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-31. If I am no longer enrolled in the HDHP, can I still make contributions to my HSA?

No. Per IRS regulations, you must be enrolled in a qualified HDHP to make contributions to an HSA.

Q-32. When will funds in my HSA be available for use?

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

Note that any employer contribution to your HSA will be communicated to you at the time of enrollment.

Q-33. How much can I contribute to my HSA?

The maximum amount you can contribute to an HSA is set by the IRS. Employer will announce the next year's limit 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 health expenses. These amounts are subject to change annually by the IRS.

Q-34. How much can I contribute if I am not enrolled in the HDHP for the entire year?

How much you can contribute depends on when you are enrolled and the date your eligibility ends. Please speak with your tax advisor or review IR Publication 969 for further details.

Q-35. 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.

Q-36. 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 HCFSA (Q-15), and may be reimbursed to you on a tax-favored basis. You can submit for reimbursements from your HSA from Optum, the HSA custodian. Edward Jones is not involved in this process and has no relationship with Health Equity other than forwarding your pre-tax elections to your HSA. If you have any questions about the HSA you should contact Health Equity. 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-37. Do I need to keep my receipts?

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

Q-38. 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-39. 14. Do I receive a debit card for my HSA?

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

Q-40. What happens to my HSA if I leave my employer or I cancel my health plan coverage?

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

PART V: PLAN ADMINISTRATION

Q-41. What happens if a claim for benefits under the HCFSA, LPFSA or DCFSA is denied?

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1:*Notice received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third-Party Administrator 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 the Third-Party Administrator, the Third-Party Administrator 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 the Third-Party Administrator 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 the Third-Party Administrator, 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 the decision of the Third-Party Administrator, you may file a written appeal. You should file your appeal with the Third-Party Administrator no later than 180 days after receipt of 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 claims reviewer.* If the claim is again denied, you will be notified in writing no later than 60 days after receipt of the appeal by the Third-Party Administrator. 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 the right to request and obtain documents, records and other information as it pertains to your claim.

Q-42. What is COBRA continuation and how does it apply to the Flexible Spending Accounts and HSA?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the HCFSA and LPFSA, but do not apply to the DCFSA or HSA.

When Coverage May Be Continued

If you are a Participant in the HCFSA and LPFSA, then you generally have a right to choose continuation coverage if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the spouse of a Participant, then you generally have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment; or
- The divorce or legal separation from the Participant.

In the case of a dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events." Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries." A child who is born to, or placed for adoption with, the Participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Healthcare FSA or LPFSA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse) must notify the COBRA Administrator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse is treated as notice to any covered dependents who reside with the spouse.

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage as a result of a Qualifying Event or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Healthcare FSA or LPFSA until the end of the Plan Year in which the Qualifying Event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The first day of the month following the month for which you fail to make a timely and complete premium payment (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or \$50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan *after you have elected COBRA continuation coverage*;
- The date that you first become entitled to Medicare *after you have elected COBRA continuation coverage*; or
- The date the Employer no longer provides group health coverage to any of its employees.

Q-43. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) group health plans such as the HCFSA 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 Employer’s health 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, or if 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>

Other Important Information

Nondiscrimination

The DCFSA 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 Company 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.

ERISA Rights

The HCSA and LPFSA portion of the Plan is an ERISA welfare benefit. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (“ERISA”). ERISA provides that all Plan Participants shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report (if any). The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage. You may continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your eligible dependents will have to pay for such coverage. You should review the COBRA section of the Plan Information Appendix for more information concerning your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration (“EBSA”) listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART VI: GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

I. COMPANY/PLAN SPONSOR INFORMATION

Name, address, and telephone number of the Company/Plan Sponsor:	Edward D. Jones & Co., L.P. d/b/a Edward Jones 1255 Manchester Road St. Louis, MO 63131 Phone: (314) 515-2000
Company's federal tax identification number:	43-0345811
Effective Date of the Amended Plan:	January 1, 2024
Plan Year:	January 1st to December 31st
8. Name, address, and telephone number of the Plan Administrator and the Agent for Service of Process: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.	Plan Administrator: Benefits Administrative Committee Edward D. Jones & Co., L.P. d/b/a Edward Jones 1255 Manchester Road St. Louis, MO 63131 Phone: (314) 515-2000 Agent for Service of Process: Assistant General Counsel Edward D. Jones & Co., L.P. 12555 Manchester Rd. St. Louis, MO 63131
9. Plan Name and Number:	501
10. Third-Party Administrator: The Plan is administered by the Plan Administrator with the help of the Third Party	HealthEquity 15 Scenic Pointe Dr., Ste 100 Draper, UT 84020 (844) 281-0433

Administrator who is responsible for processing claims under the Plan.	
11. COBRA Administrator:	
12. Sources of Contributions	Benefits are paid by Participant Salary Reductions authorized by Participants on a Pre-tax Basis that are taken solely from the general assets of the Employer.
13. Type of Plan	The HCFSA and LPFSA are intended to qualify as a medical plan under section 105 of the Code. The DCFSA is intended to qualify as a dependent care assistance plan under section 129 of the Code. HSA is not part of the Plan.