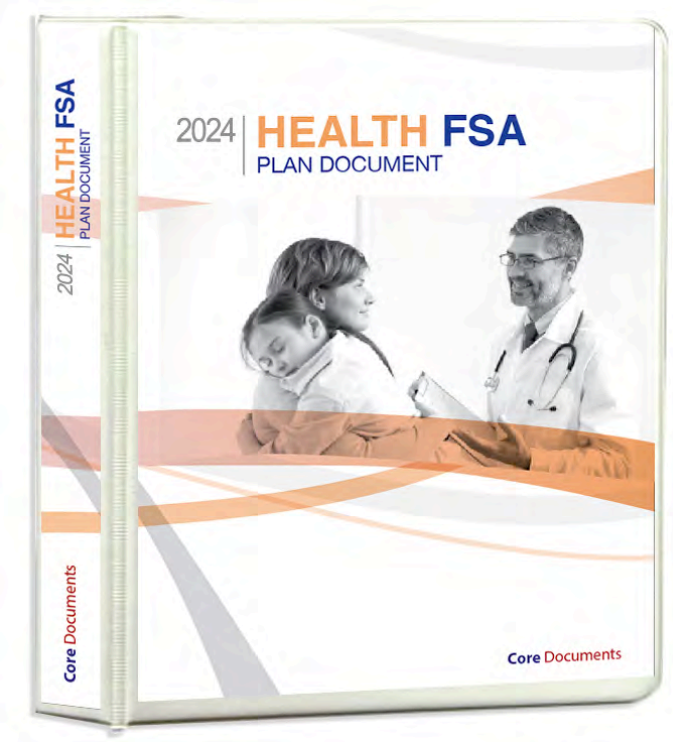
Core FSA | Health FSA Plan Document



EMPLOYEES
SAVE up to
$1,040
with Core FSA

Cover out-of-pocket medical expenses with big tax savings

The Health Flexible Spending Arrangement (FSA) allows employees to use pre-tax dollars to pay for out-of-pocket medical, dental, and vision care expenses not covered by other insurance.

Core Documents provides employers with everything they need to establish an IRS- and DOL-compliant health FSA employee benefit in the Core FSA plan document package for just $129 (.pdf format). This cost reflects a one-time setup fee, not an annual charge.

Employer Benefits

- Eliminate payroll tax on employee contributions;
- Lessen the impact of employees' deductibles, co-pays, and coinsurance gaps in health insurance.

Employee Benefits

- Eliminate taxes on contributions;
- Increase take-home pay;
- Plan ahead for out-of-pocket medical expenses.

More Features

- A Health FSA can be funded entirely by the employee (employer contributions optional);
- Employees choose how much to contribute;
- Full annual contribution amount is available the first day;
- Core FSA package pays for itself withemployer tax savings.

Big savings all around

A health FSA reduces payroll taxes for both the employer and the employee, making it a popular benefit option.

The employee does away with income and payroll tax on health FSA contributions while the employer saves 8% to 10% in matching payroll taxes:

Employee Annual Contribution	Employee Savings		Employer Savings
	Income Tax	7.65% FICA Rate	7.65% FICA Rate
$2,600	$573	$198	$198
Core FSA	$771 Total		Per employee/year

The tax benefit for the employee is like getting a huge discount on out-of-pocket medical expenses:

Per Bi-Weekly Pay Period	No FSA	With FSA
Gross Pay	$ 1,385	$ 1,385
Health Insurance Premium	300	300
Health FSA Contribution[1]	--	100
Federal Income Tax (20% rate)	217	197
Social Security (FICA; 7.65%)	83	75
State Income Tax (2%)[2]	22	20
Out-of-Pocket Medical Expenses[3]	100	--
Net Pay after Deductions & Expense	$ 663	$ 693
Net Savings on $100 Medical Expense	**--**	**$30**

1. IRS maximum contribution amount rises to $3,200 in 2024.
2. Deductible in most states.
3. Same medical expenses paid without Health FSA, using after-tax dollars.

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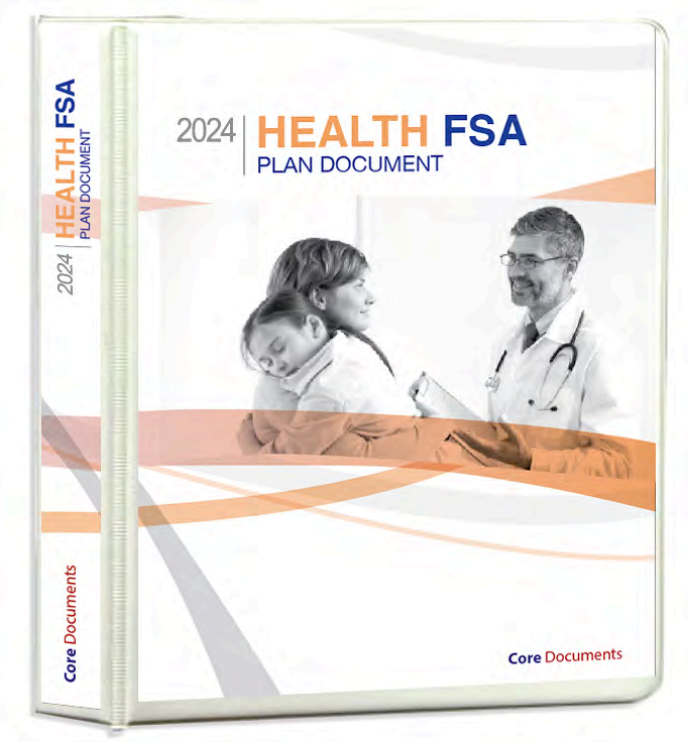

Set up a Health FSA in 3 easy steps

Design your plan:

- Choose your plan year according to the calendar (Jan-Dec) or your tax year (Jul-Jun, for example) -- a short plan year is available for the first year.
- Determine the rules and limits for your plan -- our order form takes you through it step-by-step.

Order your plan:

- Place your order for the Core FSA plan document package.
- Your personalized plan document package arrives at your inbox, usually* the same day.

Start your plan:

- Print, review, and sign the plan document where indicated;
- Give a copy of the participant packet to each eligible employee; and then,
- Keep the Core FSA plan document on file with other personnel paperwork -- there is no requirement to file the plan document with any agency.

*Most orders placed by 3 PM will be emailed out the same day, Monday through Friday. Orders placed on weekends are emailed out Monday morning.

Qualifying Health FSA medical expenses include:

- Deductibles, co-pays, and coinsurance
- Vision expenses, including LASIK, glasses, and contacts
- Dental and orthodontic procedures
- Prescription drugs
- Chiropractic services
- Diagnostic procedures
- Hearing aids
- Ambulance service
- Back, wrist, and knee supports
- Crutches and slings
- Bandages
- Artificial limbs
- Blood pressure monitors
- CPAP supplies
- Diabetic testing monitors and strips
- Flu shots
- Pregnancy test kits
- Lactation aids
- Fertility treatments
- Diabetic supplies
- Special education for learning disabilities*
- Smoking cessation programs
- Weight--loss programs*
- Telephone equipment for the deaf, hard of
- hearing, or speech impaired
- Service animals
- Wheelchairs
- Psychiatric care
- Drug addiction treatment programs (inpatient)
- Alcoholism treatment (inpatient)
- Wigs*
- Long-term care
- Nursing home
- Nursing services
- Oxygen
- Transportation
- Lodging
- Menstrual care products
- OTC medications from antacids to zinc supplements;
- And much, much more**

*When prescribed by a physician.
**For a complete list, see IRS Pub. 502.

Visit us online today

Order your Core FSA plan document package today at www.corefsa.com.

To see all of our products and services, visit us at www.coredocuments.com.

Core FSA | Health FSA Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Core FSA plan document package. It is a fillable PDF form. Click on the line next to "First Name" to begin and then tab from field to field. You may also print a blank form and write in the information. When the form is complete, go to www.corefsa.com to order your package online.

Purchaser Information (Person buying document for Employer listed below, i.e. Agent, CPA, payroll co., etc.; "N/A" in "First Name" if not applicable.)

First Name_____ Last Name_____
Company _____
Address_____
City_____ State_____ Zip Code_____
Phone _____ Fax _____
Email_____
Ship Document to: ❑Purchaser ❑Employer

Employer Information for Plan Documents – Exactly as it should appear in the plan document. Print clearly.
First Name_____ Last Name_____ (owner/controller, document signer)

Company Name_____
Address _____
City_____ State_____ Zip Code_____
Phone_____ Fax_____
Email_____
Form of Business: ❑S Corporation ❑ C Corporation ❑ LLC ❑ Partnership ❑ Sole Proprietorship ❑ Government ❑ Non-Profit 501(c)(3)

Employer Federal ID#: _____ State of Inc.:_____ Number of Employees:_____

Legal Name(s) of **Affiliated Company(ies)** that will be covered by the Plan (if any):
1)_____
2)_____
3)_____

Name of Plan Administrator: (Employer unless otherwise listed)
Name_____
Address_____
City_____ State_____ Zip Code_____
Phone_____ Fax_____

Health FSA Annual Plan Limit: The IRS limits Health FSA plans to $3,200 in employee contributions. Choose the standard $3,050 option or designate a lower employee contribution limit here. ❑ $3,200 **OR** ❑Other_____
Choose year end carryover provision for unused funds: ❑ $640 Carryover, **OR** ❑ 2.5 Month Grace Period
Protected Health Information (PHI) Designee Name:_____

Effective Date will be:
❑ a) a new plan effective date as of (date)_____
❑ b) Amend and restate an existing Health FSA plan as of (new date for this updated plan): _____
If this is an amended and restated plan, state the (old) original effective date:_____

Plan Year - The first plan year will be:
❑ a) a 12 consecutive month period beginning (date)_____ and ending (date)_____
❑ b) a short plan year beginning (date)_____ and ending (date)_____

Waiting Period: Employees can participate the ❑ 1st day of employment, or ❑ 1st day following, or ❑ 1st day of month following _____ days of employment.

Eligibility Requirements: All employees who work _____ or more hours per week.

Please tell us how you found Core Documents: ❑ Search Engine ❑Agent ❑ Google Ad ❑ Other_____

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Employer:_____

Choose either the Health FSA 'Deluxe Binder Option' or the 'Basic PDF Option':

☐ **Deluxe Binder – New Core Health FSA Plan Document** **$179.00** ☐

In email PDF version processed ASAP, AND Printed in 3-ring binder, with 5 Section tabbed index, shipped via Priority Mail.

OR

☐ **Basic PDF Option - New Core Health FSA Plan Document** **$129.00** ☐

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the Health FSA Deluxe Binder or the Basic PDF Option:

☐ **Plan Document CD Mailed - in addition to PDF email and/or mailed binder** **$25.00** ☐

Documents provided in PDF format only. Forms in MS Word format.
Always have a safe backup copy of your plan document on CD.

☐ **Rush Order - Your order automatically queued for immediate processing** **$25.00** ☐

☐ **2nd Year Update - discounted 25% when added to new document order** **$99.00** ☐

This option entitles you to one plan document amendment in the first 24 months.
Save 10% off the normal $99.00 update price.

☐ **Premium Only Plan – pre-tax insurance premium** **$99.00** ☐

Eliminate income tax on group premium. Employee saves up to 35% average, and the Employer saves matching FICA at 7.65%+. This benefit pays dividends.

Name of Benefit Programs To Be Offered:

❑ Health Insurance ❑ Dental Insurance ❑ Vision Care ❑ Group Term Life to $50,000
❑ Accident Insurance ❑ Cancer Insurance ❑ Other_____

☐ **HSA Module - pretax HSA savings for additional 7.65% tax savings** **$30.00** ☐

Allows employees to pre-tax Health Savings Account dollars for an additional 7.65% FICA savings (Employer saves matching 7.65% FICA) not available if itemized at year end.

☐ **Dependent Care Assistance Plan (FSA) Pretax childcare - Save 45%** **$71.00** ☐

Save 45% off normal $129 DCAP FSA price when added to the Health FSA.
DCAP employee contributions set at $5000 by the IRS. Delivered via email in PDF format unless the binder option is chosen above.

Update and Amend a plan document originally produced by Core Documents:

☐ **Update/Amend a Premium Only Plan Document** **$89.00** ☐

☐ **Update/Amend a Health FSA Plan Document** **$109.00** ☐

☐ **Update/Amend a Dependent Care FSA Plan Document** **$109.00** ☐

☐ **Update/Amend any 2 plan combination Document** **$169.00** ☐

☐ **Update/Amend a full 3 plan Cafeteria Document** **$249.00** ☐

All Updated/Amended documents delivered via email in PDF format.

TOTAL $ TOTAL

Core FSA | Health FSA Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

Invoice me via email, please complete the following:

Company Name: _____ **Contact:** _____

Email Address for Invoice: _____

If paying by check, please complete the following:

Your order can be processed with the following checking account information and authorization.

Name as it appears on the check:

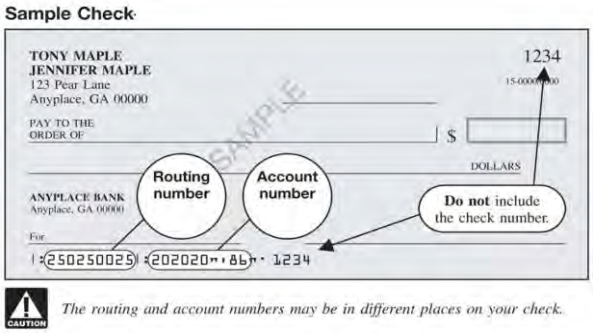
_____

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____



X_____ Date: _____
Signature

If paying by credit card, please complete the following:

Card Number: _____

Expiration Date: ____ /____

Total amount to be charged: $_____

Name as it appears on card: _____

X_____ Date: _____
Signature

Refund Policy: Purchaser understands that goods and services provided by Core Documents, Inc. are non-refundable. Orders cancelled prior to sending/shipping are subject to cancellation fees applied to the cost of goods and services provided during the review, draft, and preparation of your order.

Please sign and fax completed form to (941)795-4802. Attach additional pages of plan design information if needed.

Mail: Core Documents, Inc. P.O. Box 14538, Bradenton, FL 34280
Scan and Email: CoreService@CoreDocuments.com
Toll Free Voice: 888-755-3373 Fax: 941-795-4802