

# LOWER

Group Health Premium  
with a CORE HRA

## Flexibility, Control, Savings

Employers want to provide the best group health benefits package to employees that they can afford. Most also want maximum flexibility in plan design, and control over funding options. And, like everyone else, employers want to get the best value from every single dollar spent.

The solution that offers all of this for many employers is the Deductible Gap Health Reimbursement Arrangement (HRA).

### Flexibility

This HRA plan can be customized in several ways:

- Employers retain control of funds and decide what types of expenses will be reimbursed, in addition to whether the HRA funds will carry over from year to year.
- There are no restrictions on the type of health plan that can be paired with an HRA, so employers are free to choose the perfect plan for their employees.
- In addition, employees get to decide where and when to spend the HRA funds, as they are allowed to choose health care providers and better prices.

### Control

HRAs do not require pre-funding. Employers reimburse plan members for eligible expenses as they occur. This frees up company assets until fund dollars are needed.

### Savings

HRA reimbursements are tax-deductible for the employer and tax-exempt for employees so that everyone enjoys a tax advantage and lower premiums with a Deductible Gap HRA.

## See How a Deductible Gap HRA Brings Big Savings

### HDHP Savings

Current Group Health Plan Premium \$500,000

New HDHP Premium \$400,000

**HDHP Savings \$100,000**

### Deductible Gap to Cover with HRA

HDHP Deductible \$ 4,000

Current Deductible \$ 1,000

Change in Deductible \$ 3,000

Funding for Deductible-Gap HRA (25 EE) \$ 75,000

**Remaining HDHP Premium Savings \$ 25,000**

### HRA Distributions

Total HRA Funds \$ 75,000

Average \$2,000 Claim x 25 EE \$ 50,000

**HRA Funds Remaining \$ 25,000**

### Total Savings with Deductible Gap HRA

HDHP Savings \$ 25,000

HRA Fund Balance \$ 25,000

**Total Savings \$ 50,000**

## More Popular HRA Plan Designs

The Health Reimbursement Arrangement is the most versatile pre-tax benefit plan available, and there is a Core plan document package for every single one.

*Comprehensive HRA's* are for employers providing standard group health insurance and who would like to provide additional funds to help employees cover out-of-pocket medical expenses. Employees can also be reimbursed for excepted benefit insurance (dental, vision, cancer, etc.).

*Limited HRA's* offer nearly endless design options. One can be built to act as a Deductible Gap plan with additional funds for other out-of-pocket expenses, or set up to fund a specific medical expense (dental, vision, prescriptions) along with a standard group insurance plan, with all sorts of choices for the employer to further customize the plan.

*Premium Reimbursement Arrangement HRA* plans allow employers to reimburse employees for premiums on dental insurance, vision insurance, ancillary insurance, certain cancer and indemnity plans, and long-term care insurance – essentially most group policies and excepted benefits.

*Qualified Small Employer (QSE-HRA)* plans are similar to the PRA in that they allow the employer to reimburse employees for premiums with the added feature of reimbursing the employee for health insurance premiums purchased on their own.

*Individual Coverage HRA (ICHRA)* plans allow the employer to reimburse employees for health insurance premiums purchased on their own, plus out-of-pocket medical, dental, vision, etc. expenses.

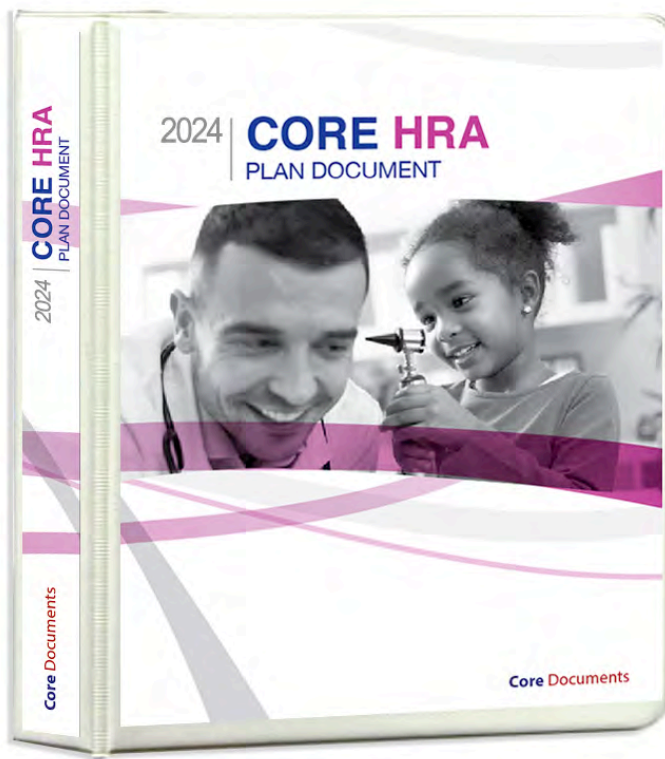
*Excepted Benefit HRA (EBHRA)* plans allow the employer with group health insurance to reimburse employees for out-of-pocket dental and vision expenses.

*One-Employee HRA's* allow the sole proprietor with one employee, usually a spouse, to take the full health insurance tax deduction available.

## Visit us online today

Order your Core HRA plan document package today at [www.corehra.com](http://www.corehra.com).

To see all of our products and services, visit us at [www.coredocuments.com](http://www.coredocuments.com).



## Set up your HRA 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; and,

### Order your plan:

- Place your order for the Core HRA plan document package.
- Your personalized plan document package arrives at your inbox within a business day or two.

### 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 HRA plan document on file with other personnel paperwork -- there is no requirement to file the plan document with any agency.

### Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Core HRA 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.

[When the form is complete, go to www.corehra.com to order online.](http://www.corehra.com)

**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 \_\_\_\_\_ Mobile \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_ Web site \_\_\_\_\_  
Ship Plan Document package to:  Purchaser  Employer

#### Employer Information for Plan Documents

(Owner/controller, document signer; exactly as it should appear in the plan document.)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Fax \_\_\_\_\_  
Email \_\_\_\_\_ Web site \_\_\_\_\_

**Form of Business:**  S Corporation  C Corporation  LLC  Partnership  
 Sole Proprietorship  Government  Non-Profit 501(c)(3)

**Employer Fed. ID #** \_\_\_\_\_ **State of Incorporation** \_\_\_\_\_ **No. of Employees** \_\_\_\_\_

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

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

#### Plan Administrator

Employer (use 'employer' information, above)  Other (provide information below)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

#### Benefit Programs to be Offered

Group Health Insurance  Dental Insurance  Vision Care  Group Term Life (Up to \$50,000)  
 Accident Insurance  Cancer Insurance  Other \_\_\_\_\_

#### Effective Date

A new plan with an effective date of \_\_\_\_\_.  
 Amend and restate an existing HRA Plan Document as of \_\_\_\_\_.  
If this is an amended and restated plan, state the (old) original effective date: \_\_\_\_\_.

**Plan Year** The first plan year will be:

A 12-month consecutive period beginning date \_\_\_\_\_ and ending date \_\_\_\_\_.  
 A short plan year beginning date \_\_\_\_\_ and ending date \_\_\_\_\_.

**Waiting Period** Employees are eligible to participate in the plan on:  the 1<sup>st</sup> day of employment, or  the 1<sup>st</sup> day following, or  the 1<sup>st</sup> day of the 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 \_\_\_\_\_



**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:

\_\_\_\_\_

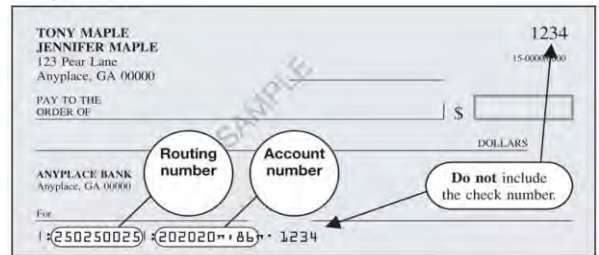
Bank Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Total amount to be charged: \$ \_\_\_\_\_

Sample Check



The routing and account numbers may be in different places on your check.

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_



**If paying by credit card, please complete the following:**

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_

Total amount to be charged: \$ \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

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

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Scan and Email: [CoreService@CoreDocuments.com](mailto:CoreService@CoreDocuments.com)

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