

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.

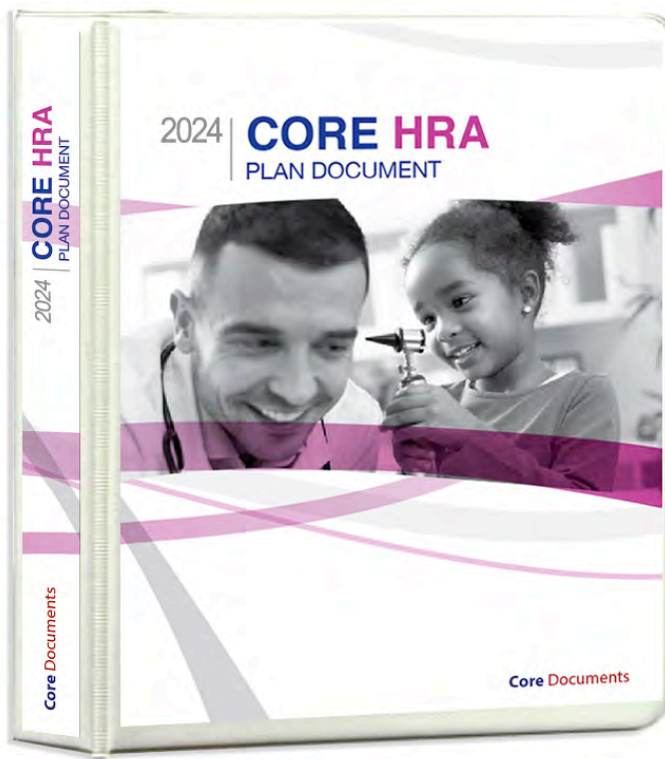
Excepted Benefit HRA (EBHRA) plans allow the employer with group health insurance to reimburse employees for out-of-pocket dental and vision expenses.

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.

To see all of our products and services, visit us at 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 1st day of employment, or the 1st day following, or the 1st 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 _____

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

Employer: _____

A Core Benefit Consultant will contact you regarding your custom plan design requests, issues, and design criteria. Please answer all of the following basic design questions that apply to the HRA benefit that you would like to provide.

Comprehensive Plan Questions:

Will your HRA plan have an annual benefit limit? Yes **OR** No If yes designate the annual limit: \$ _____

Will your HRA make the funds available: Monthly **OR** Lump Sum

Will your HRA Plan reimburse individual or Exchange insurance premium post-tax? Yes **OR** No

Will your HRA carry over unused funds at the end of the plan year? Yes **OR** No

Deductible Gap Questions:

Will your HRA Plan be coupled with your group health insurance plan? Yes **OR** No

Will your HRA Plan be designed primarily to pay a portion of the deductible? Yes **OR** No

Is your group health insurance Plan compatible with a Health Savings Account (HSA)? Yes **OR** No

Is the benefit for a calendar year Deductible? Yes **OR** No Or a Plan Year Deductible? Yes **OR** No

Is your HRA only reimbursing "in-network" provider expenses? Yes **OR** No

Is the Employee responsible for some portion of the Deductible and/or other expenses? Yes **OR** No

Please describe the Employee responsibility in your notes. Or attach notes to this order.

Premium Reimbursement Questions:

Will your HRA plan be primarily for secondary premium reimbursement (i.e. dental or vision)? Yes **OR** No

Will your HRA Plan reimburse individual or Exchange insurance premium post-tax? Yes **OR** No

NOTES: _____

Choose either the HRA 'Deluxe Binder Option' or the 'Basic PDF Option':



Deluxe Binder – New Health Reimbursement Arrangement Plan Document **\$249.00**

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 Health Reimbursement Arrangement Plan Document **\$199.00**

PDF Document Processed Quickly and Sent Via E-Mail

Options that can be added to the HRA 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 23% when added to new document order **\$149.00**

This option entitles you to one plan document amendment in the first 24 months.

Save 25% off the normal \$199.00 update price.

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

Update/Amend Health Reimbursement Arrangement HRA Plan Document **\$199.00**

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

TOTAL _____

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:

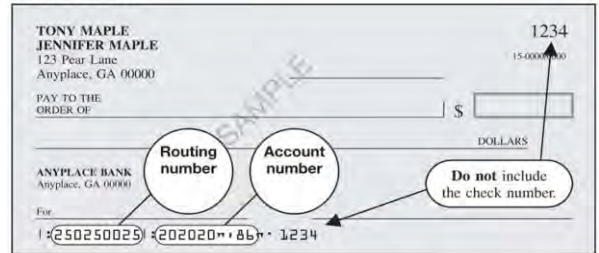
Bank Name: _____

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: _____

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