Your brokerage

RENEWAL REVIEW

Cabot Ridge Manufacturing Ltd.

Benefits review · Sun Life · Policy 71604 · Effective January 1, 2027

Cabot Ridge Manufacturing Ltd. · 318 covered members · 1-Aug-2025 to 31-Jul-2026.

Prepared by Your brokerage · September 2026

Summary

A review, not a bill. Nothing here needs a signature today.

+11.9%	The ask $98,097 → $109,792 / mo · $140,344 more a year
318	Members
$57,900	Pooled out large claims over $10,000
15.1%	Pooling charge

In this review

1 Held, not gone — $42,331 a year

Sun Life's own working calculates an increase on Long Term Disability and charges none of it. The self-insured lines below are where this year's money moved; this is what decides the next renewal.

BENEFIT	ITS OWN WORKING CALCULATES	CHARGED	HELD, A YEAR
Long Term Disability	16.8%	0%	**$42,331**

Nothing in the report says why the line is held. A rate guarantee is the usual reason: if there is one, its end date is when the working applies again. **Ask for it in writing.**

What it means for the next twelve months. A held increase is not billed later as a debt, but the working that calls for it does not go away: if the claims and the manual rate stay where they are, the January 1, 2028 renewal's working calls for it again, $42,331 a year on top of the rest of that renewal — and a competing carrier quoting this line prices them from scratch, so it is the first thing to know before the plan is marketed, and the reason "no change" on this line is not good news.

2 The funding review — $27,153 a year

- **Self-insured (ASO):** Short Term Disability, Extended Health Care and Dental Care — the employer pays these claims itself, and the carrier charges administration, pooling and margin as itemised fees.
- **Insured:** Basic Life, Dependent Life and Long Term Disability — the carrier carries the claims and prices its costs inside the rate.

Because a self-insured line's fees are billed separately rather than carried inside the rate, the loss-ratio test used on an insured premium has nothing to measure there and is not applied.

So the question is not whether a margin is fair, it is whether the **budget is the right size**. The carrier answers that itself, with two figures for every benefit:

- the adjustment its own analysis calculates the line requires, and
- the adjustment the report then charges.

Both are set out below against what the plan funds today. Nothing here is estimated — no trend, no target loss ratio — these are the carrier's own percentages applied to its current rates.

SELF-INSURED BENEFIT	FUNDED TODAY	ITS OWN WORKING REQUIRES	THE RENEWAL ASKS	DIFFERENCE
Short Term Disability	$48,911	$51,846	$54,199	+$2,353
Extended Health Care	$505,987	$581,885	$597,052	+$15,167
Dental Care	$321,432	$350,361	$359,994	+$9,633
Total	**$876,330**	**$984,092**	**$1,011,245**	+$27,153

What this is not. Money overfunded into a self-insured plan is not spent. It accumulates in the plan's ASO account, which this report puts at **$118,420**, and on most arrangements it remains the plan sponsor's. The difference above is a question about the size of the budget and who holds the cash through the year — not a claim that the plan is being overcharged.

3 The monthly budget, tier by tier

A self-insured line is billed like an insured one: a monthly rate for each member, and on short term disability a rate per $10 of benefit. What is deposited is then set against the claims and fees the plan actually pays, and the difference settles through the ASO account. These are the rates behind the funding review above, all Sun Life's own:

- **Today:** the rate billed now.
- **Its working requires:** that rate moved by the adjustment Sun Life's own working calculates for the line.
- **The renewal asks:** the renewal rate on the illustration.

MONTHLY, PER MEMBER	MEMBERS	TODAY	ITS WORKING REQUIRES	THE RENEWAL ASKS	DIFFERENCE
SHORT TERM DISABILITY ITS WORKING +6%, CHARGED +11%					
Per $10 of benefit	$220,320 of benefit	$0.185	$0.196	$0.205	+$0.009
Monthly, all covered benefit		$4,076	$4,320	$4,517	+$196
EXTENDED HEALTH CARE ITS WORKING +15%, CHARGED +18%					
Single	92	$58.40	$67.16	$68.91	+$1.75
Family	226	$162.80	$187.22	$192.10	+$4.88
Monthly, all members		$42,166	$48,490	$49,754	+$1,264

MONTHLY, PER MEMBER	MEMBERS	TODAY	ITS WORKING REQUIRES	THE RENEWAL ASKS	DIFFERENCE
DENTAL CARE ITS WORKING +9%, CHARGED +12%					
Single	92	$34.20	$37.28	$38.30	+$1.02
Family	226	$104.60	$114.01	$117.15	+$3.14
Monthly, all members		$26,786	$29,197	$30,000	+$803
All self-insured lines, a month		**$73,028**	**$82,008**	**$84,270**	+$2,263
A year		**$876,330**	**$984,092**	**$1,011,245**	+$27,153

Budgeting at the working's rates is budgeting to break even: if claims land where Sun Life's own working expects, what is deposited meets what is spent. At the renewal's rates the plan deposits $2,263 a month more, $27,153 over the year, and it lands in the ASO account (the report puts its balance at $118,420) rather than being spent.

How much cushion to budget: 10,000 simulated claim years

The working budgets for the expected year. Claims will not land exactly there, and on a self-insured plan the plan carries the difference. We simulated 10,000 claim years for a plan of this size and shape, and priced each at Sun Life's own fees:

BUDGET	A YEAR	A MONTH
Sun Life's working — the expected year	$984,092	$82,008
Enough for 3 years in 4	$1,029,760 +$45,668	$85,813
Enough for 9 years in 10	$1,073,997 +$89,905	$89,500
The renewal asks	$1,011,245 +$27,153	$84,270

The renewal's ask would have covered about **66% of the simulated years** — it already carries a cushion above the expected year. Budgeting higher builds the ASO account faster; it does not change what the claims cost.

The same levels as monthly rates. The cushion is the whole plan's, shared across the lines in proportion to each line's own: together the rates fund the plan to that level, but a line on its own is not funded to it.

MONTHLY RATE	THE WORKING	PLAN: 3 YEARS IN 4	PLAN: 9 YEARS IN 10	THE RENEWAL ASKS
Short Term Disability · per $10 of benefit	$0.196	$0.233	$0.271	$0.205
Extended Health Care · Single	$67.16	$70.15	$73.05	$68.91
Extended Health Care · Family	$187.22	$195.55	$203.63	$192.10
Dental Care · Single	$37.28	$38.35	$39.31	$38.30
Dental Care · Family	$114.01	$117.30	$120.21	$117.15

What the width comes from. These are industry-typical assumptions, not this plan's own; member-level claims or a benchmarking database would replace them.

- 10,000 simulated years, each line's cost scaled from its own required budget, since every fee on a self-insured line is a share of its claims.
- Extended Health Care: each certificate's claims varying as widely as in a typical group plan (a coefficient of variation of 1.8, the spread relative to the average), capped by pooling at $10,000 per employee and $10,000 for the dependents combined, across 318 certificates.
- Dental Care: each certificate's claims varying with a coefficient of variation of 1.1, across 318 certificates.
- Short Term Disability: claims modelled as a count, averaging the budget over one 8-week claim at the average $693 weekly benefit (a modelled 9 a year, not the plan's own count), each varying in size (coefficient of variation 0.8).
- A shared 2% uncertainty in the year's trend on health and dental.

4 Where things stand

$98,097	what the plan is billed today, per month
+11.9%	the carrier's renewal action
107.2%	paid claims against what the plan funded on short term disability

5 What's driving it

The budget being asked for is $27,153 a year above what the carrier's own working requires

Across the 3 self-insured lines:

- **Funded at the rates before this renewal:** $876,330 a year.
- **The carrier's own calculations require:** $984,092 for the renewal year.
- **The renewal asks for:** $1,011,245.

Because these are the carrier's own percentages applied to the rates before this renewal, the difference can be put to it directly.

Note what this is not: money overfunded into a self-insured plan is not spent, it accumulates in the ASO account, and on most arrangements it stays the plan sponsor's. The question is the size of the budget and who holds the cash during the year, not whether the plan is being overcharged.

The ask runs above the carrier's own working on Short Term Disability, Extended Health Care and Dental Care

- **Short Term Disability:** the working arrives at 6% and the report charges 11% — $2,353 a year. This line carries no pooling charge.
- **Extended Health Care:** the working arrives at 15% and the report charges 18% — $15,167 a year. Among the changes the fee schedule makes on this line, the pooling charge rises from 13.8% to 15.1% of claims — ask whether that is the difference, because the working does not say which charges it priced.
- **Dental Care:** the working arrives at 9% and the report charges 12% — $9,633 a year. This line carries no pooling charge.

On Short Term Disability and Dental Care, nothing on the report's pages names a cost the working leaves out: ask what the difference is for. None of this is a criticism of the carrier: the working and the charge are both its own, and each difference is a question to put to it directly.

Every dollar of extended healthcare claims avoided saves $1.20 on this plan, not a dollar

Because the plan pays its own claims, a claim avoided is money simply not paid out — in full, in the year it happens, not a share of it at some future renewal. And the administration, profit and pooling charges are levied as a percentage of claims paid, 20.25% of them on extended healthcare, so a claim that is never paid carries no fee either. That makes a dollar avoided worth $1.20. It also works the other way: a dollar of extra claims costs $1.20. Any change to plan design should be measured against that figure rather than against the claim alone.

The report states an ASO balance of $118,420: confirm what it is before counting on it

The report gives a closing ASO balance of $118,420 across all of the plan's accounts. It does not say whether that is money held for the plan or owed by it, or how much of it is spending-account float (the fee schedule lists $40,000 of float across the operating accounts). If it is a surplus, it is the plan's own money held by the carrier, and more than the whole $27,153 difference between the ask and the carrier's own requirement.

Before agreeing a budget increase, confirm:

- Whether it is a surplus, and how much of it is float.
- Whether it is refundable or can only be drawn down against future claims.
- Whether it can offset the increase rather than being added to.

The schedule sets the interest: 90-day T-bill - 0.25% on money the carrier holds, prime + 1.5% on money the plan owes.

Against that balance sits the run-off on the self-insured benefits, which no figure in this renewal quantifies. Until the carrier states it, treat the balance as partly spoken for rather than as surplus available to take or to spend down.

The pooling charge on extended healthcare is rising from 13.8% to 15.1% of claims

Pooling buys protection against a single very large claim, and its price tracks the level it attaches at: the lower the level, the more claims fall into the pool and the more it costs. At the $10,000 level the charge is $68,083 a year on last year's claims, $5,861 more than at 13.8%. Last year the charge came to about $62,221 (13.8% of claims) and the pool paid $61,450 of the plan's claims, $57,900 of them large claims: that year it paid out less than it cost. The trade at a higher level is simple to state: at $20,000, each of those large claims would have stayed on the plan for up to $10,000 more, against a lower charge on every dollar of claims. Ask Sun Life for the charge at $15,000, $20,000 and $25,000 — that answer decides it. Like the fees, it can be changed without touching anyone's coverage.

No claims reserve is held on the benefits you fund yourself

The experience exhibits for extended healthcare print "Change in IBNR Reserve" with no amount against it, so incurred claims are set equal to claims paid. On the self-insured benefits it is yours. Claims incurred before a change of carrier, of funding basis, or a wind-up, and paid after it, fall to the plan sponsor in cash at that moment, and nothing in this renewal is set aside for them. That is not a criticism of the arrangement — matching paid to incurred is the normal way to run a continuing ASO plan, and while it continues the two roughly offset. It matters on the day it stops. For scale only, and not as an estimate of the liability: extended healthcare paid $450,880 of claims last year, $37,573 a month.

6 What running the self-insured lines costs

On the benefits the plan funds itself, each fee is charged as a share of the claims paid: these are the Sun Life fee schedule's charges, line by line, most of them guaranteed for 12 months.

BENEFIT	ADMINISTRATION	CLAIMS HANDLING	PROFIT	POOLING	TOTAL, % OF CLAIMS	A YEAR, ON LAST YEAR'S CLAIMS
Short-Term Disability	1.5%	6.9%	0.25%	—	**8.65%**	$4,533
Extended Healthcare	1.5%	3.4%	0.25%	13.8% → 15.1%	**20.25%**	$91,303
Dental	1.5%	3.1%	0.25%	—	**4.85%**	$14,458

Each charge is a separate line in the fee schedule and is negotiable on its own terms. Where the schedule says so, a charge is taken on claims less pooled claims, which is the figure used here.

7 Getting the plan back on track

These are the usual changes for a plan of this size and shape, priced on **your own claims**. Without the plan booklet on file, each assumes the plan does not already have it — switch off any it does, and the total follows. The drug figures are shares of the claims total, pending the prescription drug report. Because the plan pays its own claims, each is worth the claims it avoids, in full and in the year it happens; the trims underneath are real but small, there for when you want them.

> **MODELED CLAIMS SAVINGS, WITH THE CHANGES ON**
>
> **−$81,109** a year, out of the claims the plan pays
>
> A modelled figure, not a quote: each change at a point inside its range, stacked so no claim is counted twice. It assumes none of these is in place today, and the drug figures are pending the prescription drug report. Switch off any the plan already has.

CHANGE	ESTIMATED SAVING	INCLUDED
Managed drug formulary Tiered formulary with step therapy on high-cost classes — the structural drug lever. *Assumes the plan is on an open formulary today; range pending the prescription drug report.* **In plain terms:** On an open formulary the plan pays for whichever drug is prescribed. A managed formulary is a preferred list: where several drugs do the same job, the plan covers the best-priced one first, and steps up to costlier options when the doctor confirms they're needed. The same conditions get treated — the plan just stops paying premium prices by default.	$13,526–$40,579 a year	In the total
Dental recall to every 9 months Trims routine spend at the hygienist. *Assumes recall is every 6 months today.* **In plain terms:** A recall is the routine cleaning and check-up. Many offices book every 6 months out of habit; for most healthy adults, 9 months is clinically ordinary. This changes how often the plan pays for routine visits — anything a dentist flags as needed is still covered.	$11,924–$26,830 a year	In the total
Mandatory generic substitution Reimburse at the generic price unless no-substitution is medically required — largely invisible to members. *Assumes generic substitution is not already mandatory; range pending the prescription drug report.* **In plain terms:** Most brand-name drugs have a chemically identical generic version at a fraction of the price. This sets the plan to pay the generic price by default. Members still get the brand when the doctor writes that substitution isn't appropriate — or by paying the small difference themselves.	$9,018–$27,053 a year	In the total
Hold to the prior-year dental fee guide Trims fee inflation; usually invisible to members. *Assumes the plan reimburses at the current-year fee guide.* **In plain terms:** Each province's dental association publishes a fee guide every year, and prices creep up with it. Holding reimbursement to the prior year's guide means the plan does not automatically absorb this year's increase. Most dentists bill at the current guide, so a member may see a small balance — typically a few dollars a visit — where the plan once covered the whole amount.	$5,962–$17,887 a year	In the total

CHANGE	ESTIMATED SAVING	INCLUDED
Dispensing-fee cap Steers volume to lower-fee pharmacies without cutting coverage. *Assumes the plan has no dispensing-fee cap today; range pending the prescription drug report.* **In plain terms:** Every prescription includes a pharmacy service fee on top of the drug itself, and it varies by store — a few dollars at some pharmacies, over $12 at others. A cap sets the most the plan reimburses for that fee; members using pricier pharmacies can switch, or cover the difference.	$4,509–$22,544 a year	In the total

More trims (1)

CHANGE	ESTIMATED SAVING	INCLUDED
Prior authorization on specialty drugs Guards the tail: specialty drugs are the fastest-growing part of drug spend, and one claimant can outweigh a year of ordinary prescriptions. *Assumes the plan does not already require prior authorization; at the $10,000 pooling level much of a specialty claimant's cost is paid by the pool, not the plan, so less of this reaches the plan's own claims; range pending the prescription drug report.* **In plain terms:** A handful of specialty drugs can cost more than everything else on the plan combined. Prior authorization means the carrier confirms one of those prescriptions is the right fit before it starts paying. For almost everyone this changes nothing at all, because almost nobody is on one of these drugs. A member who is prescribed one waits on an approval step, and the plan is protected from the largest single surprise a drug plan can produce.	$9,018–$36,070 a year	Not in the total

What we still need from you

- **The benefits booklet.** It confirms what the plan already has, so each change above can drop the assumption it carries, and it prices what cannot be priced without it: combine / reduce paramedical maximums, trim the vision allowance, reduce the dental annual maximum, introduce a health deductible and health coinsurance step-down.
- **The prescription drug report** — a Top DIN listing or the carrier's drug claims report. It turns the drug ranges above into analysis of this plan's own prescriptions.

None of these decisions are due today. We run the carrier, the paperwork, and the staff communications end to end.

8 The renewal, line by line

Every benefit, what you pay today against the renewal. The renewal column is the carrier's ask as this report states it. Nothing in it has been negotiated yet.

BENEFIT	CURRENT / MO	RENEWAL / MO	CHANGE
SELF-INSURED (ASO) BENEFITS			
Short Term Disability	$4,076	$4,517	+10.8%
Extended Health Care	$42,166	$49,754	+18%
Dental Care	$26,786	$30,000	+12%
Self-insured (ASO) benefits subtotal	**$73,028**	**$84,270**	**+15.4%**
INSURED BENEFITS			
Employee Life	$3,836	$4,289	+11.8%
Dependent Life	$235	$235	+0%
Long Term Disability	$20,998	$20,998	+0%
Insured benefits subtotal	**$25,069**	**$25,522**	**+1.8%**
Total	**$98,097**	**$109,792**	**+11.9%**

The experience behind it

Two figures for each benefit. The first is raw: this period's paid claims (on health, less what the pool paid) against what the plan funded. The second is Sun Life's own final loss ratio — after its retention and, where they apply, trend, fee guide, claims incidence and pooling — the figure its rate action is set from. In the first column, over 100% means claims ran past what the plan funded. Credibility is how much of your own result the carrier uses.

BENEFIT	PAID CLAIMS ÷ FUNDED	CARRIER'S FINAL LOSS RATIO	CREDIBILITY
Extended Health Care	89.1%	100.6%	100%
Dental Care	92.7%	92.7%	100%
Short Term Disability	107.2%	97.9%	100%

9 The road ahead, with your selections

Every saving above has an operational half — what actually changes for your staff. This list follows the switches: flip a change off and its consequences leave with it.

- **Managed drug formulary**
  New prescriptions in managed classes start on the preferred option; moving off it needs the prescriber's supporting note. Existing therapies usually carry over — we confirm the carrier's grandfathering in writing before anything changes.
- **Dental recall to every 9 months**
  Routine cleanings move to every 9 months. The dental office books on the plan's schedule once told — one line in the member notice covers it.
- **Mandatory generic substitution**
  Pharmacists fill the generic unless the prescriber writes no-substitution; a member who insists on the brand pays the difference at the counter.
- **Hold to the prior-year dental fee guide**
  Reimbursement holds at the prior-year fee guide, so members may pay a small difference where a dentist charges current-year rates.
- **Dispensing-fee cap**
  Members at higher-fee pharmacies pay the difference or switch — we provide a list of low-fee pharmacies nearby.

Every change is communicated to staff before it takes effect — we draft the notice, file the carrier amendment, and take the questions.

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10 The cushion already in place

Claims above **$10,000 a year per employee, and $10,000 again for the employee's dependents combined,** are pooled across the carrier's whole book, not carried by your plan alone. This period **$57,900** of large claims was absorbed by that pooling, and a further $3,550 of out-of-country claims was pooled from the first dollar — the carrier's ratios above are already net of it; the paid-claims column is before it.

11 What happens next

ACTION	WHEN
We check the carrier's working on this renewal This review is our line-by-line check of the letter in hand. On a self-insured plan that means each benefit's calculated adjustment against the one being charged, the fees against the retention the budget was priced with, and any increase calculated on an insured benefit and then held. Anything that does not reconcile is the first thing we take back to the carrier.	Done: this review
Turn on regular experience monitoring Get experience on the tightest cadence the carrier will produce, quarterly where it offers it, so a benefit crossing a threshold is caught while the window is still open and there's time to act, not reconstructed at renewal when it's already locked.	Now
Implement amendments + member communication Roll out the agreed plan-design changes and brief members on what changed and why, especially any new or lower maximum. Clear communication means members hear the why before they reach it — it protects trust; it doesn't make a lower maximum not a takeaway.	Upcoming — at renewal (Jan 1, 2027)