Your brokerage

RENEWAL REVIEW

Fundy Tire Inc.

Benefits review · Canada Life · Policy 204417 · Effective May 01, 2026

Fundy Tire Inc. · 40 covered members · January 01, 2025 - December 31, 2025.

Prepared by Your brokerage · September 2026

Summary

This renewal took effect May 1, 2026. Below: what it says, and how to set up May 1, 2027.

+32.3%	The May 1, 2026 renewal $7,835 → $10,365 / mo · $30,364 more a year
40	Members
75.96%	Target loss ratio
$5,377	Pooled out pooled below the $15,000 large-claim level
20.07%	Pooling charge

> **SETTING UP MAY 1, 2027 — THE WINDOW IS STILL OPEN**
>
> Fundy Tire Inc. renews May 1, 2027 (≈7.1 months). Canada Life is expected to rate it mainly on Jan 1, 2026 – Dec 31, 2026 claims — you're 74% through that window with ~14 weeks left to move the experience-rated number. After Dec 31, 2026 the experience locks; the remaining levers are pooling, plan design, census accuracy (the demographic re-rate), and the negotiation.

In this review

1 The reconciliation — health, drugs, dental and vision

Health, drugs, dental and vision are the lines the carrier prices at least partly on your own claims, so they are the only lines a claims argument can move. Employee Term Life, AD&D, Dependent Life and Employee Critical Illness are not priced on your claims. They are listed beneath at the carrier's ask, and the two together are the whole-plan figure of $124,384/yr.

$115,642	the carrier's ask on health, drugs, dental and vision, per year — +33% · $9,637/mo · 93% of the $124,384 whole-plan ask
$118,200	the premium your health, drugs, dental and vision claims support — our independent analysis · +35.9% Built from $61,959 of claims on those lines, scaled 26.4% up to $78,298 in step with today's rated premium (the report prints no headcount for the claims period): trended forward at the market norm for these lines (11% a year) over 1.33 years to the middle of the coming plan year, converted to premium at your 75.96% target loss ratio, then weighted line by line to your own experience against the carrier's own manual rate for each line, at the weights the carrier states (97.5% and +22.8% claims-weighted across the lines). The step from claims to premium is the carrier's admin, commissions and margin.
$2,558	below what your health, drugs, dental and vision claims support at the market trend — carried forward by the carrier · 2.2% of the health, drugs, dental and vision ask

The carrier is asking $2,558/yr less than your health, drugs, dental and vision claims support even at the market trend (11% a year). That is not a saving: it is a shortfall the carrier is carrying into next year, and the following renewal will look to recover it. The pages below are about getting ahead of that — the plan changes you make now are what shape the number you see then.

Outside the reconciliation, carried at the carrier's ask: Employee Term Life ($4,333/yr), AD&D ($586/yr), Dependent Life ($540/yr), Employee Critical Illness ($3,283/yr) — priced on demographics, volume or a flat fee, not on this group's claims. With that added back the letter's whole-plan ask is $124,384/yr (+32.3% overall).

2 What the carrier keeps

The 76% target loss ratio already gives the carrier **24% of every premium dollar** for administration, commissions and margin. What a renewal asks above that is the carrier's view of next year: its trend and, where it does not rate the group fully on its own claims, its manual rate. This is what each number would

keep, against this year's claims, held flat, with the ask and the renewal brought to that year's exposure.

ON HEALTH, DRUGS, DENTAL AND VISION, PER YEAR	PREMIUM	CLAIMS	CARRIER KEEPS	SHARE
Last year, premium at today's rates	$70,646	$61,959	$8,687	12.3%
The renewal	$91,511	$61,959	$29,552	32.3%

The renewal raises the carrier's share of your health, drugs, dental and vision premium from 12.3% to 32.3%, 8.3 points above the carrier's own target if claims hold at last year's level; whatever next year's trend adds comes out of that. The claims year carried less exposure than today's rate sheet — $70,646 of premium against $89,275 for a full year at today's rates, and the report prints no headcount for it — so the ask and the renewal are shown at their percentages on that year's premium rather than at their full-year dollars. The reconciliation above grants the carrier a market trend for the whole horizon; this table grants it none. The negotiation lives between the two.

3 What's driving it — trended adjusted loss ratio

Drug	137.3%
Health	73.6%
Dental	59.3%
Vision	84.2%

The dashed line is the 75.96% target — anything above it is costing you rate.

$5,377 pooled out-of-country, not off a large claim

This plan pools out-of-country claims from the first dollar, and $5,377 came out that way. It sits below the $15,000 large-claim level, so the large-claim pool absorbed nothing this period. The pooling charge is 20.07%. Lowering the pooling level would not have caught this — out-of-country is already pooled at the first dollar, and it raises the pooling charge, which is priced off the level. Confirm the current charge against what the carrier quotes at the next level up before treating the level as a lever.

One therapeutic class is 46.9% of drug spend

This therapy accounts for $20,643 of drug spend — 46.9%. Chronic and non-discretionary: it is a forecasting input rather than something to design out. It is the dominant variable in next year's renewal.

4 Where this is heading

Next year's expected claims against **today's premium**. The gap to the target is what the renewal's increase is priced to close; plan changes close it from the other side, by lowering the claims. The figure below is where it starts, before any of the changes on the following pages.

No changes, at today's premium	100%

target 75.96% · −$6,518 / yr in claims About $6,518 a year comes out of the experience the carrier rates before the next renewal is priced. 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.

5 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. The package below is sized against the gap to target; the trims underneath are real but small, there for when you want them.

The changes on by default do not reach the target on their own; the gauge shows how far they go.

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.	$1,561–$4,683 a year	In the total

CHANGE	ESTIMATED SAVING	INCLUDED
Mandatory generic substitution One therapeutic class is 46.9% of drug spend. 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.	$1,041–$3,122 a year	In the total
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.	$520–$2,602 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.	$258–$773 a year	In the total

More trims (2)

CHANGE	ESTIMATED SAVING	INCLUDED
Prior authorization + biosimilar program on specialty drugs One therapeutic class is 46.9% of drug spend — this targets the actual dollar driver. *Assumes the plan does not already require prior authorization; at the $15,000 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.	$1,041–$4,163 a year	Not in the total
Dental recall to every 9 months Dental claims ran at 59.3% of premium last year — healthy. Housekeeping, not the rescue. *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.	$515–$1,160 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.

6 The renewal, line by line

Every benefit, before the renewal and after it. The renewal column is what took effect May 1, 2026, as this report states it.

BENEFIT	LIVES / VOL.	BEFORE / MO	RENEWAL / MO	CHANGE
POOLED BENEFITS				
Employee Term Life	976,000	$273	$361	+32.1%
AD&D	976,000	$49	$49	+0%
Dependent Life	30	$34	$45	+31.6%
Employee Critical Illness	380,000	$232	$274	+18%
Pooled benefits subtotal		**$588**	**$729**	**+23.9%**
HEALTHCARE				
Single	12	$174	$171	−1.9%
Family	26	$956	$937	−2%
Healthcare subtotal		**$1,130**	**$1,108**	**−2%**
DRUGS				
Single	12	$556	$913	+64.2%
Family	26	$3,066	$5,034	+64.2%
Drugs subtotal		**$3,623**	**$5,947**	**+64.2%**
DENTAL				
Single	12	$265	$267	+0.7%
Family	26	$1,654	$1,666	+0.7%
Dental subtotal		**$1,919**	**$1,933**	**+0.7%**
VISION				
Single	12	$88	$100	+12.8%
Family	26	$486	$549	+12.8%
Vision subtotal		**$575**	**$648**	**+12.8%**
Total		**$7,835**	**$10,365**	**+32.3%**

The experience behind it

The carrier's trended loss ratio by benefit — the claims figure its own working rates on, carried forward to next year, against premium. Anything over the 75.96% target is running above what it's priced for. Credibility is how much of your own result the carrier uses.

BENEFIT	TRENDED LOSS RATIO	CREDIBILITY
Drug	137.3%	97.5%
Health	73.6%	97.5%
Dental	59.3%	97.5%
Vision	84.2%	97.5%

7 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.
- **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.
- **Dispensing-fee cap**
  Members at higher-fee pharmacies pay the difference or switch — we provide a list of low-fee pharmacies nearby.
- **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.

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

8 The cushion already in place

Claims above **$15,000 a year (per person, per family, or per employee and separately for dependents, as the contract sets it)** are pooled across the carrier's whole book, not carried by your plan alone. About **$5,377** was pooled out this period, and the figures above are already net of it. It sits below the $15,000 threshold, so it did not come from a claim that pierced this pool — see the pooling note above for what it was.

9 What happens next

ACTION	WHEN
We check the carrier's math at the renewal letter When the renewal letter lands, we verify it line by line against the analysis behind this review — the pooling, the trend factor, the credibility — before anything is accepted.	Upcoming — at the renewal letter (expected about Feb 15, 2027)
We negotiate before anything is accepted The trend factor and the credibility behind the increase are negotiated, not fixed. If the number stays high, phasing it across the year is on the table.	Upcoming — at the renewal letter (expected about Feb 15, 2027)
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 (May 1, 2027)

10 A tax-smart alternative: an HSA for health & dental

Fund health and dental through a Health Spending Account instead of insured premiums. A premium buys insurance, and the carrier keeps its margin whether the plan is used or not; an account pays claims as they happen, so you pay for what is used plus an administration fee. The allocation is set from today's health and dental premium, whoever pays it now; Life, AD&D, Dependent Life and Critical Illness stay insured. Claims stay tax-free to your team, as they are under an insured plan today. For a large claim, a catastrophic (stop-loss) policy can sit behind the account at a premium of its own, which the figures below do not include; without one, claims above an employee's allocation are theirs to pay.

> **TAX-FREE HEALTH DOLLARS FOR YOUR TEAM**

$78,267 a year

worth ~$120,411 in salary at an assumed 35% marginal rate

90% of today's $86,963 health & dental premium, funded as allocation

$172	per covered employee, per month (an annual allocation; unused dollars can carry forward one year where the plan allows, which raises that year's most-it-can-cost)
$87,268	what you'd pay at expected utilisation; you fund only what's claimed. costs $305 more (0.4%) against today's $86,963 premium; $28,374 against the $115,642 renewal, the like-for-like year
$9,131	of claims above the allocation in aggregate at this funding level

Caution:
At a 101% loss ratio, the allocation plus the account's fees costs more than today's premium — break-even is about 90%. Keep this insured, or set the allocation below the claims it would have to cover. **Last year's health & dental claims came to $61,959.** You paid $67,837 in health & dental premium for it — the 101% loss ratio above is the FORWARD figure: this group's claims trended into next year against the premium the carrier rates on, which is why it runs higher than last year's own 91% — the rest is the insurer's margin and coverage that went unused. That same $61,959 of claims on the HSA runs about $69,084 all-in — that is this plan priced at **last year's actual claims**, where the $87,268 above prices it at **expected utilisation**. Two scenarios of the same plan, not two answers to the same question.

Only pay for what your team uses

IF YOUR TEAM CLAIMS...	YOU PAY (HSA, ALL-IN)	VS STAYING INSURED AT $115,642
40% of the allocation ($31,307)	$34,908	save $80,734
60% of the allocation ($46,960)	$52,360	save $63,282
80% of the allocation ($62,614) your history sits here (79%)	$69,814	save $45,828
100% of the allocation ($78,267)	$87,268	save $28,374

Last year's $61,959 of claims is about **79%** of the allocation; next year's expected claims are about **112%**, the figure to plan on.

Fully-insured, you pay the full $115,642 renewal premium every year, claimed or not. With the HSA you fund only what's used plus the flat fee, so you come out ahead until usage runs very high, and you keep whatever's left instead of the insurer.

The full plan, three ways — per month

BENEFIT	CANADA LIFE YOUR RENEWAL	CANADA LIFE MODELED EST.	BENIPLUS HSA ROUTE	CANADA LIFE NEXT RENEWAL'S START, WITH YOUR SELECTIONS
Employee Term Life	$361	$343	$361 unchanged	$361 unchanged
AD&D	$49	$46	$49 unchanged	$49 unchanged
Dependent Life	$45	$43	$45 unchanged	$45 unchanged
Employee Critical Illness	$274	$260	$274 unchanged	$274 unchanged
Health	$7,704	$7,668 est.	**$7,272** HSA, expected claims	$6,815
Dental	$1,933	$1,924 est.		$1,856
Total / month	**$10,365**	**$10,284**	**$8,001** −22.8%	**$9,400** −9.3%

The fourth column is **next renewal's starting point**, not this year's bill: this year's renewal on health and dental, less the claims your selections remove, at the same loss ratio and before trend. It moves with the switches above; the pooled lines carry across unchanged.

Life, AD&D, Dependent Life and Critical Illness **stay insured** under the HSA route — same protection, unchanged. The real move is health & dental: fully-insured you pay a fixed premium whether it is used or not; on the HSA you fund only what is claimed. Canada Life is **modeled** from the same claims-supported figure as the reconciliation above, re-priced at a 78% target loss ratio (our assumption for Canada Life, from the renewals we have seen, not a figure it publishes), with the insured lines at a representative new-business rate — an estimate, not a bound quote; a submission confirms it. Read it as a sanity check on the ask, not as a quote to compare against. The fully-insured market is competitive; the HSA is the structural saving.

Annual allocation per employee

COVERAGE	/ MONTH	/ YEAR
Single (12)	$81/mo	**$975**/yr
Family (26)	$213/mo	**$2,560**/yr

Single and Family follow how the plan is rated today. One flexible account per person, allocated annually.

What each allocation buys

COVERAGE	SINGLE	FAMILY
Prescription drugs (anything above it needs stop-loss, if added)	$475	$1,360
Dental	$300	$700
Paramedical / practitioners	$150	$350
Vision	$50	$150
Total	**$975**	**$2,560**

Each column is that allocation carved into typical category maximums. In practice it's one flexible account — any dollar is spendable on any CRA-eligible expense.

More flexible than the insured plan

- **100% reimbursement** up to the allocation. No coinsurance haircut, no per-category maximums eating the value.
- **Far broader eligibility.** Any CRA-eligible practitioner, drug, dental, and vision expense — the employee directs the dollar to what they actually need, not a fixed list of categories.
- **You control the allocation.** It doesn't get re-rated up by a bad claims year the way an insured renewal does.
- **Follows real need.** Claims mix shifts year to year; a fixed-category insured plan pays for coverage that goes unused, an HSA never does.

How it's paid for

Administered by

Pay-as-you-go, no insurance premium. You fund the claims your team actually makes, plus BeniPlus's fee:

- **10%** on approved claims, only when staff actually use the benefit
- **15% HST** on that fee alone; claims paid to members carry no HST. Whether a provincial premium tax applies to an HSA in New Brunswick is confirmed with the administrator before this is quoted
- **No monthly fee and no deposit** to get started

Two ways to run it: a **refund account** where you fund claims as they land (lowest cost, variable), or a **fixed monthly amount** that behaves like a premium if you'd rather budget one predictable number. Worst case, if every allocated dollar is used, the program runs about $87,268.

It's not insurance — but no one falls off the rails

An HSA is a spending account, not an insurance policy. For the rare catastrophic case, three layers can sit behind it so a member is not left carrying a large claim alone. Which of them apply depends on the design you choose:

- **Stop-loss pooling behind the account.** Pair the wallet with a major-medical / catastrophic policy — an available add-on — so claims above the account, or above a drug cap if the design sets one, are carried by the pool, not the member.
- **New Brunswick's public drug programs.** A member facing a catastrophic drug cost may qualify for provincial coverage of some high-cost drugs, coordinating part of the cost off the plan. Eligibility differs by program, some carry a premium or an income test, and it is confirmed member by member.
- **Manufacturer compassionate-care programs.** Drug makers run patient-support programs for their high-cost therapies — bridging, copay assistance, and free-drug programs for those who qualify.

Only the first is coverage, and it is priced separately. The other two can help with a high-cost drug, but neither is guaranteed: without stop-loss, a claim above an employee's allocation is theirs to pay.

Why tax-free matters. A health-account dollar reaches your team tax-free, as an insured benefit does today; the change from insurance is paying for claims instead of premium, not the tax. Against paying for care out of salary, someone at 35% would have to earn about $154 for every $100 spent. That rate is an assumption: lower earners pay less tax, so the difference is smaller for them.

Employer-deductible, tax-free to employees, CRA-compliant under a Private Health Services Plan. Figures are modeled from your current premium and claims; BeniPlus, the plan administrator, confirms before anything changes. HSA pricing per BeniPlus, July 2026.

11 One platform for HR, payroll, and benefits

The same login your team uses for benefits also runs onboarding, time off, and payroll — one record, no double entry, through Employment Hero.

Plan	HR Premium + Payroll
Price	**$22/emp/mo** $880/mo · $10,560/yr across 40 employees
Made up of	HR Premium $15/emp · Payroll $7/emp
What's included	Everything in Standard, Custom workflows & branding, Advanced time-off, 1:1s & 360 reviews, Goals & OKRs, Single sign-on (SSO), Full payroll processing — pay runs, remittances, T4s, ROEs

Pricing per Employment Hero, July 2026; confirmed at enrolment. Premium ($15), Platinum ($19), and Employment Unlimited ($65) tiers add scheduling, performance, and fully-managed payroll.