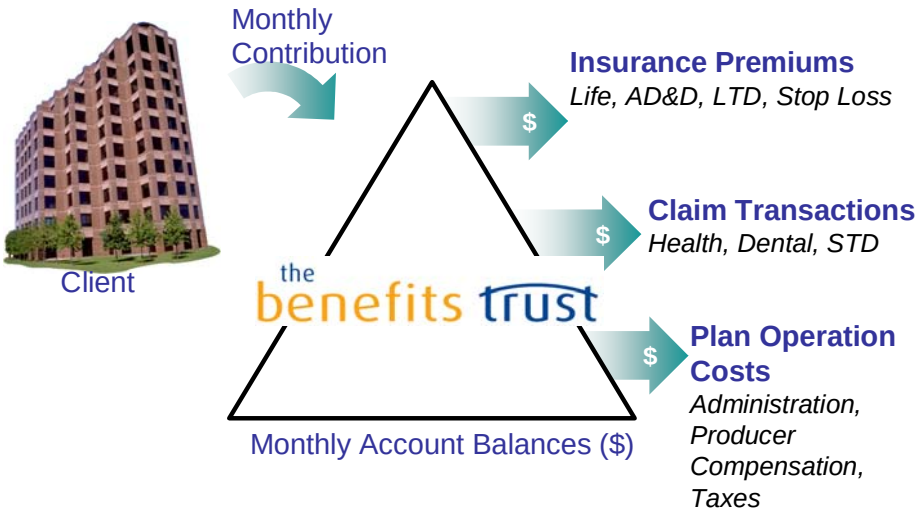
Overview

Creative Employee Benefit Solutions

OPERATION OF
THE BENEFITS TRUST



INTRODUCTION

Employee benefits are a required component of an employee's compensation package.

Often, employee benefits costs form a significant portion of corporate compensation expenses, and these costs are escalating. Benefit programs are important to employees, who are seeking to protect themselves and their families from government downloading of medical costs, and the possibility of catastrophic events.

A number of changes in the insurance industry are also having an impact on employee benefits plans. Through industry consolidation and the de-mutualization of very large insurance companies, we are seeing significant structural changes in corporate practices. Customers may experience varying levels of service due to personnel and profit pressures.

In light of these factors, it is imperative that Canadian companies have an appropriate employee benefits plan design which meets both the needs of their employees and corporate compensation objectives; and that this benefits plan is costed appropriately according to employers budgets, the marketplace and the insurance industry.

The Benefits Trust can assist you to achieve your strategic employee benefits objectives in a cost effective manner.

TRADITIONAL GROUP INSURANCE

Employee benefits costs are escalating at a much higher rate than the overall rate of inflation. This is a characteristic of traditional fully insured group benefit plans, whose rates automatically increase when outside factors change. Some of these factors include: escalating drug costs caused by extended patent protection, new and expensive drug therapy treatments, and shifts from government coverage to private coverage. These trends are ongoing.

Insurance companies design and package group insurance plans to accommodate their administrative systems as well as the needs of the client. The result is usually a generic plan design with little flexibility.

Insurance companies spread the risk associated with loss of life, long term disability, and other catastrophic claims over a large population. There is no way of accurately predicting what these low frequency, high expense claims will be.

Medical and dental claims are also insured under traditional group insurance plans. These expenses occur frequently, but are relatively low cost. As a result they <u>can</u> be predicted and budgeted for, and funded through a managed fund as opposed to insurance.

THE BENEFITS TRUST PROVIDES ADDED RISK PROTECTION

There are two key components to a benefits plan: insurance to protect against risk, and administration to effectively handle transactions.

- *Life Insurance, A.D. & D., Dependant Life and Long Term Disability* benefits are risk intensive, and require insurance.

- *Health and Dental Care* benefits are administrative in nature. These benefits operate primarily on a "money in, money out" principle rather than requiring traditional risk insurance.

Administrative Services

Extended Health and Dental benefit expenses are most economically covered by examining the group demographics, benefits plan design, and claims experience of each employer. From this information, we can establish a contribution budget for claims expenses and set up a managed fund that will meet these claims. We monitor employee claims experience to refine the prediction model and the budget.

The claim funds are held in trust, and properly managed, they will meet the claims cost. Each individual corporate employer member of the Trust is responsible for all of its own claims costs, plus plan operation costs. The Trust does not hold excess funds in reserve, so that your money remains under your control, not locked away at the insurance company.

THE BENEFITS TRUST PROVIDES ADDED RISK PROTECTION (CONTINUED)

Catastrophic Risk Insurance

Catastrophic risk elements of the benefits plan (Life Insurance, A.D. & D., Dependant Life and Long Term Disability) are insured through a Canadian Life Insurance Company in a traditional fully insured pool. The Trust arrangement provides the additional advantage of group buying power as well as security.

Exposure to catastrophic medical claims, such as some of the new "prescription drug cocktail" treatments, is limited with Stop Loss insurance above a certain pre-established limit. The limit quoted for your plan is $5,000 per insured individual, per year.

Stop Loss insurance is designed primarily for potentially catastrophic health care claims such as prescription drugs, hospital claims, and out-of-country claims. Out-of-country claims are fully insured (pooled) from the first dollar claimed. All other expenses are fully insured after a $5,000 deductible per person in each calendar year. Other health care claims such as paramedical services are covered by Stop Loss insurance, but these claims will be limited to their prescribed maximums within the benefit services contract.

The Benefits Trust allows you to purchase insurance protection where appropriate, and allows you to control and budget health and dental care expenses associated with low cost, high occurrence claims. The end result is you have greater control over your benefits costs and more flexibility in benefit plan design.

PLAN FUNDING AND REPORTING

The primary difference between a traditional fully insured benefits plan and plan operated through The Benefits Trust lies in the timing. Fully insured plans present annual renewals that may result in large premium increases after the fact. Claims information may come too late to be effective. Even if regular reporting is provided, it is likely in a format that is convenient for the insurer to produce, but difficult for you to analyze or use effectively. In addition, premium adjustments may not fit with your budgeting process, or may come at difficult times in your business cycle.

With The Benefits Trust, an annual contribution budget is set. Monthly costs normally only change due to employee enrollments, status changes and terminations. However, reporting on surplus or deficit status is provided on a monthly basis, by the business units you determine, to track and control claim costs as they happen. This information assists in the day-to-day management of your business.

Insurance companies will seek to recover expenses in excess of their predetermined target loss ratio. This cost recovery is done through reserve accumulation and rate increases. The actual dollar figures are often hidden or unclear. The Benefits Trust identifies any disparity between contributions and claim costs directly rather than recovering costs out of reserves. Plan operation costs are identified clearly on a monthly basis.

Surplus or deficit amounts are tracked and reported monthly. A surplus of one to three months' contributions is your account target, to allow for claim fluctuations. These funds belong to you, and will be refunded when requested. Deficit amounts are closely monitored to determine if a claim trend is developing, or if a claim "spike" has occurred. An accumulating deficit may be addressed through any combination of direct deficit payments, budgetary adjustments or benefit level adjustments. The budget is designed to accommodate your projected claims experience, with a margin for unanticipated fluctuations.

IS YOUR COMPANY COVERED FOR THE RIGHT RISK?

An increasingly important and strategic question in group benefits is whether employers are covered for the right risk. The answer to this question is changing due to many innovations in health care. Prescription drugs for certain medical conditions are now being prescribed at a cost of $30,000 to $40,000 per year and more. These medications are for ongoing treatment, and could be required by the individual for a period of several years. A single claim will have a negative and significant financial impact on the future cost of your employee benefits program.

Your company likely has 100% credible claims experience when evaluated by your current insurance carrier. This means that all claims are applied directly to your experience rating at renewal, with the exception of some Large Amount Pooling. Any significant claim costs, particularly large recurring claims, can result directly in premium increases. This may put your company at significant financial risk due to recent innovations in Health care.

Some insurers, in response to the increasing risk of large health care claims, are offering excess medical stop loss insurance. This insurance pools the risk of all health care claims by one individual in excess of a pre-determined limit within one year. With The Benefits Trust, claims in excess of the insurance limit of $5,000 per person per year are insured and do not count against the employer's experience when setting health care budgets.

Excess medical stop loss insurance would provide greater protection for your company.

THE ADVANTAGES OF PERSONALIZED SERVICE

The insurance industry is under increasing pressure to be more profitable. This pressure is having a direct impact on the level of service provided to clients. Like many other segments of the financial services industry, insurance companies have established call centres.

Call centres have a number of advantages. A high volume of inquires can be handled in a day, in a cost effective manner. Call centres work to minimize the waiting time experienced by clients calling in.

However, there is usually some waiting time in the voicemail system of the call centre. Another disadvantages are impersonal service, and no flexibility for exceptions or special service. Any situations requiring creative solutions are referred to another department with another wait.

When you and your employees call in to The Benefits Trust, you will reach a person, not a queue in the voicemail system. You will speak to your company's assigned Client Service Specialist. The Benefits Trust provides very rapid turnaround on routine claims and on special cases.

Our service representatives are trained to adjudicate your employee benefits plan according to your requirements. We will help you to get your job done faster and better.

ADMINISTRATIVE SERVICES

Our services will include:

- Daily claims adjudication and payment.
- Employee inquiries handled by our client service specialists through telephone, fax and email interaction.
- Maintenance of accurate employee benefit records.
- Monthly billing statements (by division and by department as required), identifying benefits costs for each employee in each division.
- Account changes and billing adjustments carried out by The Benefits Trust.
- Formal benefits plan documentation to satisfy all legislative requirements concerning private health services plans prepared by The Benefits Trust contract specialists.
- Complete Administration Manual which clearly outlines procedures and provides forms for notification of employee status changes.
- Monthly financial status reporting, including the current month, year to date, and prior year to date for on-going monitoring and trend analysis, with a monthly commentary.
- Employee information meetings at implementation, and regularly as needed.
- Employee communication materials such as benefits brochures and booklets, announcement memos, annual benefit statements.
- Wallet certificate cards provide each member with their contract number and individual certificate number, coordinated with electronic dental claims processing (EDI dental) if desired.

Our team of specialists at The Benefits Trust and our advanced systems can help meet and exceed your company's needs.

Directory of CONSULTANTS
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Are Self-funded Benefits Nirvana?

Rethinking Delivery Of Employee Benefits

By: Robert J. Crowder

The rise of third-party benefit administrators is making Administrative Services Only plans an option to control health benefit costs for employers large and small. Robert J. Crowder, of Nelson B. Crowder & Associates Inc., explains how they work and some of the advantages of taking this approach.

With healthcare costs escalating out of control, smart employers are thinking differently these days and using a new funding method – self-insurance – to finance employee benefit plans.

Once confined to large companies such as banks and railways, self-insurance – using an Administrative Services Only (ASO) contract – is now a viable option for smaller enterprises, thanks to a blend of better technology, developments in financial and insurance products, and the rise of third-party benefit administrators.

A benefit plan can be divided into two parts.

There is an insurance component to cover a catastrophic event such as long-term disability, the death of an employee, or an unforeseen need for special medicines or treatments.

Then there is a cash contribution component used to pay for everyday benefits such as drug costs or dental care.

A self-insured arrangement for benefits coverage provides employers with more flexibility, cuts down on administration costs, and gives firms greater control over the amount they actually spend on benefits. That's because employers only pay for what they use.

Traditionally, most firms have simply purchased a benefit plan through an insurance company. That was fine when benefit plans were first introduced and multiple insurers were competing to provide employers with options.

Events Conspiring

However, a number of events are conspiring to force employers to think about benefits differently.

First, consolidation and demutualization of the insurance industry means fewer competitors and options when it comes to plan selection. The offerings are more generic and apply a one-size-fits-all approach to benefit planning.

Second, rates are skyrocketing. While the cost of inflation has been running between two to three per cent, insurers have been hiking the cost of their benefit plans significantly higher. Healthcare inflation trend factors used by insurance companies are averaging increases of 18 to 22 per cent annually.

In the group insurance industry, insurers spread the risk associated with loss of life, long-term disability, and other catastrophic claims over their entire client base, so employers pay similar rates within their industry regardless of their claims record. There's no way for insurers to accurately predict what these low-frequency, high-expense claims will be at each employer, so the risk is spread across many employers based on actuarial assumptions. This is the purpose of pure insurance – to cover high-cost, unpredictable losses.

On the other hand, medical and dental claims occur frequently but are relatively low cost. Claims experience in a group tends to remain relatively stable when monitored over time. As such, you can predict and budget for these types of expenses.

Rainy Day Fund

However, insurance companies often look to recover more in expenses than what they pay out, so when they get it wrong, they simply hike their rates or increase their claim reserves.

Reserves are an ill-understood concept that insurance companies use to protect themselves should an employer with high claim costs decide to terminate the relationship and move elsewhere. It's an amount over and above what they actually think it will cost them to insure an event, a rainy day fund if you will. Frequently, reserves are explained as funds held to protect the employer in the event of unexpectedly high claim costs, or 'run-off claims,' paid out after a contract ends.

I look at it differently. I say it's there to protect the house and we know, in the long run, the house always wins.

Because of the consolidating market, employers have fewer options. If they don't like the annual renewal increases, then the insurer shrugs its shoulders. In the past, employers had nowhere else to go.

Well, now employers have another option. ASO plans are finding their way to the market through third-party benefit

administrators, which manage the program on behalf of the employer.

Here's how they work.

First, the third-party benefits administrator protects against risk by assessing the correct type of insurance coverage needed to cover the catastrophic event component. This depends on a number of factors, ranging from the type of business to the number of employees. The administrator works with group insurance brokers and insurance firms to obtain quotes and find the appropriate stop-loss insurance plan that fits the employer's needs. By separating the pure insurance component from the budgeting portion of the plan, the administrator can take advantage of group buying power and shop for lower rates, which are passed onto the employer. Typically, group benefits consulting and administration businesses purchase stop-loss insurance with a $5,000 deductible to protect the employer from catastrophic medical claims such as prescription drug 'cocktail' treatments (some of which can run $30,000 to $40,000 annually), hospital claims, or private duty nursing expenses. Out-of-country emergency medical expenses are also fully insured, usually with no deductible.

Monies Placed In Trust

When it comes to the self-insured health and dental care component, the administrator and the employer work together to establish a budget for those items, and the monies are placed in trust with the administrator, which runs the plan and adjudicates claims. Employees, or their healthcare providers, simply submit their claims directly to the administrator which processes them and issues claim cheques. Some administrators can issue health cards for purchases like drugs and medical devices.

The administrator's job is to monitor the claims experience and help clients develop a better understanding of their true costs. If, at the end of the year, there are surplus funds left in the trust account, they are either returned to the employer or become part of the budget for the next year's claims and the employer need only top up the fund.

Alternatively, if the account is 'overdrawn,' the employer must make up any deficit with additional contributions. The plan can be monitored monthly and spikes in claims can be quickly identified and dealt with.

As well, the flexibility of a self-insured health and dental plan allows employers to reward loyalty. They can set up a phased-in benefits schedule so that more benefits are provided the longer the employee remains with the company. You can also budget for benefits across an organization according to profit centres and category of employee or management level. This will assist the employer to further understand the source of their true benefit costs.

These plans work best with organizations that employ 15 or more people. The employer usually pays the administrator a percentage of self-insured contributions as a plan operation fee. The strategy applies to any industry – from retail to manufacturing – and for most business structures – from family-owned companies to professional firms.

While benefit costs have been rising, experience with the self-insurance model over the past five years shows a number of employers have had minimal increases in the costs of their benefits coverage.

So are self-funded benefits nirvana? Not necessarily. But for the average employer, they open the door to a whole new way of thinking about benefits and how best to structure a plan that meets the needs of both employers and employees, while providing the flexibility needed to grow a successful company. ■

Robert J. Crowder is the president of Nelson B. Crowder & Associates Inc.

Things To Watch For In A Third-party Administrator

When it comes to selecting a third-party administrator to assist in your efforts to create a self-insured benefit plan, there are several key things you need to identify.

- How long has the company been in business and is it an experienced provider of services for your size of company? Employers need a benefits administrator that has been around the block a few times and knows the complexities involved. The administrator should be a solid and reliable player, so don't be afraid to ask for client references.
- Can the company meet your specific requirements? Do they have previous experience in setting up plans such as yours? Check to see that the firm has the necessary staff resources, such as actuaries, and access to skilled medical and dental professionals.
- Check out the technology. The key to containing costs lies in the ability of the provider to track and manage the plan with no fuss or muss. What is the turnover time for processing claims? How does the adjudication process work? What are the reporting procedures? Will it provide a drug card if you want one?

By shopping carefully, employers can find a partner who will help take their benefits management to the next level. ■

BENEFITS AND PENSIONS MONITOR

Reprinted from Benefits and Pensions Monitor – August 2003

APPENDICES

The Benefits Trust C.V. .....Appendix A
Sample Billing Statement.....Appendix B
Sample Monthly Financial Statement .....Appendix C

THE BENEFITS TRUST

Inception:	January 1, 1994
Purpose:	To appropriately administer the employee benefits plans of our member employers according to their written benefits promise, and to account individually for their funds placed in trust.
Administrator:	The Benefits Trust Inc.
Senior Medical Consultant:	Dr. Raymond Rupert, M.D., MBA
Senior Dental Consultant:	Dr. Ron Jacobs, D.D.S.
Financial Institution:	TD Canada Trust
Auditors:	Burns Hubley LLP
Liability:	Directors and Officers Liability Errors and Omissions Liability Insured through American Home Assurance Company
Participating Industries:	Education Finance / Investment Management Food and Beverage Services Hospitality Services Manufacturing Medical Care Nursing Care Property Management

THE BENEFITS TRUST – Monthly Contribution Statement

01-Jan-11

CLIENT #:317

ABC INC.

							COVERAGE					PREMIUMS										
								CRITICAL					CRITICAL		STOP		PREM					
MEMBER	CLASS	SIN	SEX	D.O.B.	START	S/F	LIFE	ADD	CARE	STD	LTD	LIFE	ADD	CARE	STD	LTD	MED	DENT	LOSS	TAX	PST	TOTAL
Division: *002 Western Canada*																						
Dept: *4 Manufacturing*																						
CLARK EDWARD	D	123-456-789	M	16-May-52	01-Jun-00	F	75,000	75,000	0	500	2,081	25.50	3.00	0.00	47.30	58.6	0.00	87.62	0.00	1.75	17.77	241.62
DIRKS ANDREA	B	789-123-456	F	12-Sep-51	01-Jun-00	F	139,000	139,000	0	500	2,564	47.26	5.56	0.00	47.30	72.3	85.16	87.62	5.31	3.44	28.04	381.99
HALL PETER	B	456-489-123	M	02-Feb-44	01-Jun-00	S	277,000	277,000	0	500	4,600	94.18	11.08	0.00	47.30	129.	34.20	35.09	5.31	1.38	28.55	386.81
MAZEROLLE GEORGE	D	512-458-123	M	19-Aug-7	01-Jun-00	S	52,000	52,000	0	350	1,445	17.68	2.08	0.00	33.11	40.7	26.52	35.09	5.31	1.22	12.84	174.60
MCDONALD ROBERTA	D	852-147-963	F	21-Dec-51	07-May-01	S	55,000	55,000	0	366	1,511	18.70	2.20	0.00	34.62	42.6	0.00	0.00	0.00	0.00	7.85	105.98
PEAT MICHAEL	B	741-258-369	M	29-Dec-64	12-Jun-00	S	133,000	133,000	0	500	2,450	45.22	5.32	0.00	47.30	69.0	34.20	35.09	5.31	1.38	19.32	262.23
								Department Totals				248.54	29.24	0.00	256.93	413.14	180.08	280.51	21.24	9.17	114.37	1,553.23
Dept: *5 Shipping*																						
DWYER BART	F	852-456-178	M	26-Jun-75	01-May-01	F	46,000	46,000	0	308	0	15.64	1.84	0.00	29.14	0.00	65.96	87.62	5.31	3.06	16.44	225.01
KITT JOHN	F	946-248-412	M	13-Jul-67	01-Jun-00	S	47,000	47,000	0	315	0	15.98	1.88	0.00	29.80	0.00	26.52	35.09	5.31	1.22	9.17	124.97
TRAINOR ANNE	F	851-456-741	F	23-Jul-71	01-Jun-00	F	46,000	46,000	0	304	0	15.64	1.84	0.00	28.76	0.00	65.96	87.62	5.31	3.06	16.41	224.60
								Department Totals				47.26	5.56	0.00	87.69	0.00	158.44	210.33	15.93	7.34	42.02	574.57
								Division Totals				295.80	34.80	0.00	344.63	413.14	338.52	490.84	37.17	16.52	156.39	2,127.80

THE BENEFITS TRUST - Statement of Adjustments

CLIENT #:317

						COVERAGE					PREMIUMS											
MEMBER	CLASS	SIN	TYPE	START	S/F	LIFE	CRITICAL ADD	CARE	STD	LTD	LIFE	CRITICAL ADD	CARE	STD	LTD	MED	DENT	STOP LOSS	PREM TAX	PST	TOTAL	MTHS
Dept: *5 Shipping*																						
DWYER BART	F	852-456-178	6	01-May-01	F	46,000	46,000	0	308	0	15.64	1.84	0.00	29.14	0.00	65.96	87.62	5.31	3.06	16.44	225.01	1
							Department Totals				15.64	1.84	0.00	29.14	0.00	65.96	87.62	5.31	3.06	16.44	225.01	
Total						**46,000**	**46,000**	**0**	**308**	**0**	**15.64**	**1.84**	**0.00**	**29.13**	**0.00**	**65.96**	**87.62**	**5.31**	**3.06**	**16.44**	**$225.01**	

Change Types:

1) Class 2) Coverage 3) Earnings 4) Rate 5) Termination 6) New Member 7) Override

THE BENEFITS TRUST - Monthly Contribution Statement

01-Jan-11

CLIENT #: **317**

ACTIVE MEMBERS **9**

ABC INC.
ADMINISTRATION OFFICES
LONDON
ONTARIO N7A 3N8

MICHAEL PEAT
DIRECTOR OF OPERATIONS

	LIFE	ADD	OPTIONAL LIFE	CRITICAL CARE	LTD	STOP LOSS	STD	MED	DENT	PREM TAX	PST	TOTAL
Coverage Totals	870,000	870,000	0	0	14,651		3,643					
Property Totals	295.80	34.80	0.00	0.00	413.14	37.17	344.62	334.92	490.84	16.52	156.39	2,127.80
Current Totals	330.60				413.14	37.17	344.62	334.92	490.84	16.52	156.39	2,127.80
Adjustments Totals	15.64	1.84		0.00	0.00	5.99	29.14	65.28	87.62	3.06	16.44	225.01
Final Totals	**348.08**				**413.14**	**43.16**	**373.75**	**403.80**	**578.46**	**19.57**	**172.83**	**2,352.80**

GST **GST No. 895499630RT** **25.10**

Total Amount Payable **$2,377.90**

PLEASE MAKE NOTE OF THE FOLLOWING

1. Please make cheques payable to "THE BENEFITS TRUST inc." and send to The Benefits Trust by the first of the month.
2. If an employee terminates or status changes, please return a "NOTICE OF TERMINATION" Or "CHANGE OF RECORD" form as soon as possible.
3. For each new employee to be enrolled in the plan, please return a completed "EMPLOYEE BENEFITS APPLICATION" form.
4. Please inform The Benefits Trust of any changes in earnings for covered employees.
5. If an employee wishes to change his/her beneficiary, please return a "CHANGE OF RECORD" form.
6. Please return an "OVERAGE DEPENDANT" form for each eligible dependant age 21 or older who is a student.

PLEASE SEND ALL CORRESPONDENCE TO:

THE BENEFITS TRUST INC.
3800 Steeles Avenue Road West. Suite 102W
Vaughan, Ontario L4L 4G9
PHONE: (905) 264-8990
FAX: (905) 264-1123

The Benefits Trust
Sample Company Inc.
January 31, 2011

	Current	Year To Date	Last YTD
Contributions			
Life	514.83	3,005.04	2,627.10
LTD	1,321.56	7,695.95	6,288.62
Stop Loss	450.00	2,610.00	2,437.50
Short Term Disability	0.00	0.00	0.00
Critical Illness	0.00	0.00	0.00
Dental	1,350.86	7,834.92	7,134.32
Medical	3,127.94	18,125.98	16,908.57
Travel Assistance	26.30	153.03	0.00
Health Care Spending Account	0.00	84.16	0.00
Administration Fee on HCSA	0.00	8.42	0.00
Total Contributions	6,791.49	39,517.50	35,396.11
Insurance Paid			
Life	514.83	3,005.04	2,627.10
LTD	1,321.56	7,695.95	6,288.62
Stop Loss	450.00	2,610.00	2,437.50
Critical Illness	0.00	0.00	0.00
Travel Assistance	26.30	153.03	0.00
Claims Paid			
Short Term Disability	0.00	0.00	0.00
Dental	367.18	2,912.26	6,400.47
EHC:			
Hospital	180.00	180.00	0.00
Vision	100.00	400.00	300.00
Drug Card	2,462.24	12,259.42	8,382.85
Prescription Drugs	390.11	1,206.46	4,590.28
Paramedical	21.35	3,997.67	3,004.95
Out of Province	0.00	0.00	0.00
Medical Services	0.00	300.00	330.00
Total EHC	3,153.70	18,343.55	16,608.08
HSA Claims	0.00	84.16	0.00
Total Claims Paid	3,520.88	21,339.97	23,008.55
Plan Operating Expenses			
Plan Operation Costs	783.79	4,543.15	4,328.94
Adjustments	0.00	0.00	0.00
Surplus(Deficit) Bal.Fwd.	0.00	7,291.48	0.00
Deficit Payment	0.00	0.00	0.00
Returned/Applied Surplus	0.00	0.00	0.00
Balance	174.13	7,461.84	(3,294.60)

1453 Pelham St.,
Fonthill, Ontario
L0S 1E0

Phone: (416) 498-7723
Toll Free: (800) 487-2993
Fax: (905) 264-1123

www.thebenefitstrust.com