Maximum benefit.

Stop Loss Insurance

PROTECTING THE FINANCIAL INTEGRITY OF YOUR BENEFIT PLAN

Many employers, looking to gain control of their employee benefit plan costs, turn to Administrative Services Only (ASO) plans. Using ASO health and dental components in your group plan is a highly effective method of managing costs by covering predictable claims. And, in order to provide financial protection against large, catastrophic medical claims, employers normally purchase **Stop Loss** Insurance, which reimburses the employer for those expenses which exceed a specified deductible level.

Maximum Benefit has retained The Co-operators® to provide extensive Stop Loss coverage for your health care program. You can choose one of five levels of coverage, from $10,000 to $25,000, per insured person. All active employees, and/or retirees with a drug cap in place, qualify for Stop Loss coverage. If retirees do not have a drug cap in place when the firm elects Stop Loss coverage, a drug cap must be established before retirees are eligible.

All eligible health claims over the purchased Stop Loss level are transferred to the insurer, capping the risk to the employer.

Stop Loss terminates at age 85 for all active employees and eligible retirees.

WHO IS INSURED?

The difference between Stop Loss and conventional employee benefit insurance is that Stop Loss insures the employer, not the employees and dependents covered under your health plan.

WHAT LEVEL OF COVERAGE SHOULD WE CHOOSE?

Your advisor can help you determine your optimal coverage by balancing your plan benefits, financial resources, loss histories, tolerance for risk, and other factors.

CAN WE CHANGE THE LEVEL OF STOP LOSS COVERAGE WE HAVE?

Stop Loss coverage levels may be changed on the anniversary date, provided no claims in excess of the elected Stop Loss amount have been made or are likely to be made.

WILL STOP LOSS INSURANCE COVER CLAIMS FOR DISABLED EMPLOYEES?

Claims of disabled employees can be covered for Stop Loss coverage for up to 24 months from the date of disability. In certain situations this coverage may be extended.

CONTINUED

OUR PLAN CURRENTLY HAS AN INDIVIDUAL WHO IS CLAIMING A SIGNIFICANT AMOUNT UNDER OUR HEALTH PLAN. HOW DOES THAT AFFECT OUR STOP LOSS COVERAGE?

Stop Loss insurance is for the purpose of covering unknown catastrophic risks. It is not intended to cover risks that are known. In these situations, you have three options:

- the individual can be excluded from Stop Loss coverage and the employer can assume the financial risk of providing benefits to the claimant, or
- the standard Stop Loss premiums can be levied a surcharge allowing the individual to be covered under the Stop Loss coverage, or
- the individual must exceed a preset claims limit that is equivalent to their total extended health claims for the preceding 12 months before becoming eligible for Stop Loss coverage.

DOES STOP LOSS COVERAGE AFFECT PLAN DESIGN?

Your plan document defines the benefits you are offering to your employees. Because self-funding allows you latitude in designing the plan, there could be elements of your plan that are not included under the Stop Loss coverage.

Though Maximum Benefit Stop Loss coverage is quite comprehensive, there are limitations that you should be aware of as you design your health plan. These are highlighted in the table to the right.

HOW ARE STOP LOSS CLAIMS PAID?

The Stop Loss claims process is transparent to the employer. Should an individual exceed the Stop Loss level, Maximum Benefit will co-ordinate the claims process with the insurer.

The individual's claim is adjudicated and eligible expenses are reimbursed to the individual or provider of services or supplies.

Maximum Benefit will assess the claim against the Stop Loss insurer. None of these amounts are charged to you, nor will they reflect on any of your monthly management reports. At the benefit plan's year-end, a summary of claims paid by the Stop Loss insurer is included in the renewal information presented to you.

STOP LOSS INSURANCE WILL NOT COVER THE FOLLOWING CLAIMS:

- Paramedical practitioner claims in excess of $1,500 per calendar year
- Private duty nursing costs in excess of $25,000 per calendar year
- Per diem semi-private, or private hospital room charges which are in excess of the insurer's "reasonable and customary" schedule
- Services or supplies associated with:
  - erectile dysfunction in excess of $5,000 per insured person per calendar year
  - the diagnosis or treatment of infertility in excess of $15,000 per insured person per calendar year
  - contraception, other than oral contraceptives; birth control injections; and birth control patches
- Any treatment related to or provided for drug addiction, other than prescription drugs