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|---|---|
| Policy: Stop Loss Underwriting Guidelines | Policy No: 02-01-01 |
| Policy Developer(s): Phil Holowka, Kristen Joyce, Michael Wilson, Jamie Holowka | Committee Oversight: Underwriting Committee |
| Original Publish date: 4/17/25 | Approval Date: 10/3/25 |
| Last Review: | |

## 1. Preface:

**At medTRANS Insurance Ltd., the paramount objective of the underwriting function is to protect the financial assets of our current clients. This principle forms the foundation of our underwriting philosophy and guides every decision within the Underwriting Department.**

**Underwriters are charged with viewing prospective groups in one of two ways. Either as existing clients or as new opportunities. Existing clients benefit from an established claims history that provides clarity and accuracy in risk assessment. As such, their underwriting treatment can be more flexible and data-driven because prior performance allows for a more precise forecast of future liabilities.**

**Conversely, new opportunities represent the most financially precarious segment of the underwriting landscape. Generally, these groups come to medTRANS with incomplete claims histories, fragmented data, or none at all—requiring underwriters to make projections amidst greater uncertainty. As a result, all new business must be approached with heightened scrutiny, elevated conservatism, and a risk-averse mindset. Conservative underwriting is not only prudent; it is necessary to uphold our fiduciary duty to existing clients and their shared risk pool.**

**medTRANS is not in the business of issuing speculative illustrative quotes or non-binding rate indications without the purpose of issuing a proposal. Each underwriting decision has the potential to affect the financial well-being of every member in the risk pool, and as such, new business must be priced with integrity, caution, and an unwavering commitment to protecting the collective interests of our insureds.**

**Fairness, consistency, and professionalism must guide all renewal underwriting activities. Consultants with a proven track record of supporting risk aversion and cost containment within medTRANS will be considered during the review. While specific service providers should not be expected to have any influence over objective underwriting judgment, EVER. Some types of vendors (ex., specific network types) may be acknowledged as an advantage for clients. Clients are expected to accept**

**renewal terms that reflect their demonstrated experience, rather than negotiated expectations.**

**This guideline is intended to memorialize these standards and ensure every underwriter within medTRANS understands the importance of our mission: to grow responsibly, evaluate risk thoroughly, and always put our clients' interests first.**

## 2. Policy:

a. It is the policy of medTRANS Insurance Ltd. to apply a collaborative, disciplined, consistent, and data-driven approach to underwriting new stop-loss opportunities. This approach promotes financially sustainable growth for the captive while ensuring equitable and risk-conscious policy issuance aligned with medTRANS' underwriting methodology and the standards of its Board and Underwriting Committee.

## 3. Purpose and Scope:

a. This policy governs the underwriting of new employer group stop-loss insurance policies. It ensures that proposals are evaluated with a consistent methodology, leveraging the enforce carrier's renewal rates and robust claims data, where available.
b. This policy governs the underwriting of current(*renewing*) employer group stop-loss insurance policies. It ensures that proposals are evaluated with a consistent methodology and robust claims data.
c. This policy applies to:
    i. All first-year stop-loss opportunities underwritten by medTRANS Insurance Ltd.
    ii. All renewal stop-loss opportunities underwritten by medTRANS Insurance, Ltd.
    iii. All underwriting staff and clinical reviewers responsible for risk evaluation.
    iv. All requests for proposals received by CCMS on behalf of medTRANS.

## 4. Procedure

a. The following are Plan Sponsor[1] policy request attributes

| Description | Attribute |
|---|---|
| Minimum number of covered employees[2] | 20 |
| *Group size between 20 and 50 requires the underwriter to Escalate to senior management* | |
| Minimum specific deductible | $50,000 |
| Specific lifetime maximum | Unlimited |
| Maximum aggregate limit | $4,000,000 |
| Minimum aggregate corridor | 100% |
| Maximum run-in limit | 6 months |
| Maximum run-out limit | 24 months |

[1] The Plan Sponsor is the employer offering the employer sponsored health benefits plan
[2] Although medTRANS is permitted to write down to 20 covered employees lives on the "plan" it is not desirable to allow employers with under 50 covered lives.

| | |
|---|---|
| As of the policy effective date, the enrolled employee average age must be less than, regardless of plan sponsor size. If the average age is greater than 50.0 DTQ is the automatic response. | 50.0 |

b. Data elements needed to start work for each of the **3 categories**

**i. Self-fund currently**

| |
|---|
| Member[3] census (*see min requirements in policy 05-01-02)* |
| Aggregate claims report (*current and last year's completed, if applicable for coverage*) |
| 50% report (current year at minimum) |
| Claimant(s) who breached specific limits (current and previous policy year) |
| Prescription claims for all subscribers[4] for the current period |
| Current health plan attributes |
| Minimum of 2 years of network access history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |
| Minimum of 2 years of TPA history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |
| Minimum of 2 years of PBM history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |
| Ability to satisfy the underwriter's and/or clinical director's questions on enrolled members. If answers are not deemed satisfactory, the Director of Underwriting has full authority to deny to quote. |

**ii. Fully insured currently (less than 100 employees)**

| |
|---|
| Member census (*see min requirements in policy 05-01-02*) |
| Monthly claims report (*if possible*) |
| High-cost claimants (*current and previous policy year, if possible*) |
| Prescription claims for all subscribers[5] for the current period (*if possible*) |
| Current health plan attributes |
| Minimum of 2 years of rate history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |
| Minimum of 2 years of carrier history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |

**iii. Fully insured currently (greater than 100 employees)**

[3] A member is the employee who is currently working for the employer or a COBRA election

[4] A subscriber is any person on the plan. This would include dependents

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|---|
| Member census (*see min requirements in policy 05-01-02*) |
| Monthly claims report (*to include month-over-month premium to claims*) |
| High-cost claimants (*current and previous policy year)* |
| Prescription claims for all subscribers[6] for the current period |
| Current health plan attributes |
| Minimum of 2 years of rate history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |
| Minimum of 2 years of carrier history; *the underwriter has full discretion to request additional prior years' worth of data to complete the underwriting background further* |

**c. The following are Minimum Plan Sponsor attributes**

| |
|---|
| Plan Sponsor location(s) |
| Proposed effective date |
| Proposed third-party administrator |
| Proposed pharmacy benefit manager |
| Proposed managed care provider and/or reference-based repricing vendor |

**d. Desired policy attributes**

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|---|
| Desired specific deductibles (pick up to 3, min of $50,000) |
| Policy duration (12-month period is the default, unless instructed otherwise) |
| Policy term (default is run out with a 6-month tail, unless instructed otherwise) |
| No commissions are paid to the consultant |
| Only with senior management approval shall a policy term exceed 12 months, but under no circumstances shall it be longer than 15 months |
| At a minimum, the expiring and previous policy documents |

e. Eligibility and Risk Indicators: **In order of priority**

i. **Red FLAGS require a second set of eyes**

| |
|---|
| Inconsistent data or inconsistencies in the story<br>• ask questions and get valid answers<br>○ ***Unanswered underwriter questions, discovered in the future, are grounds for negative performance reviews*** |
| Unusual pressure from TPA/Broker<br>• **When a broker bypasses the Director of Captive Strategies or its subordinate staff and renders an opinion or pressures the underwriter, this warrants immediate discussion with the Director of Captive Strategies and/or executive leadership.**<br>• In some instances, it may be warranted to have the broker complete the medTRANS Insurance, Ltd "Broker Conflict Attestation." |

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|---|
| Excessive change in carriers<br>• 3 carriers or more in 5 years, when underwriting requests additional data<br>• Mid-year carrier change without a substantive reason |
| Frequent changes to managed care network<br>• 3 networks over 4-5 years<br>• If Fully Insured & first year carrier renewal is greater than 15% |
| Recent growth or shrinkage without a substantive reason |
| Group has been on a 12/12 contract now requests a run-in contract |
| Recent experience is not made available |
| If incumbent renewal has been made, but not shared |
| Recent acceleration of claims<br>• Past 3 months exceeds claims since policy effective date |
| Inconsistent run-in or run-out reports |
| Unusually good experience – if it looks too good to be true, it likely is |
| Any unlisted item that defies logic or the general method of underwriting<br>• **When in doubt, consult with the Director of Underwriting and/or the Director of Captive Strategies** |
| If the average age of the population is less than 50.0 years old as of the first day of the policy, AND there is greater than 10% of the population aged 65 or older. |

f. Ideal Group Characteristics

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| Eligible groups should be single-employer groups. |
| Groups currently covered by multiple carriers must be replaced in total by the TPA/Health Plan. Unless approved by Executive management, dual offerings are not permissible |
| Desired participation is 75% of those eligible for contributory plans and 90% for non-contributory plans. If participation is between 50% and 75% and has been consistent for the last 3 years, the underwriter should proceed with caution. If it is less than 50%, it must be escalated to senior management |
| Employees must work a minimum of 30 hours per week to be considered full-time, 24 hours per week for schools and hospitals. |
| Early Retirees (under age 65) should not exceed 10% of the total group population. Additional scrutiny should be applied to municipalities. |
| Retirees 65 and over should be covered primarily by Medicare and secondarily by the employer's plan. |
| The addition or sale of divisions, mergers or acquisitions of companies during the policy period is not automatically eligible. |
| medTRANS Insurance does not pay any commission to 3rd party. |
| Coverage can only be bound when:<br>1. Currently Self-Funded – 9th Month's agg report is in hand<br>2. If no agg coverage is purchased, then 9 months' worth of claims reporting<br>3. Currently Fully Insured – incumbent carrier's renewal offer is in hand |

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| Employer Groups must be an eligible industry. Below are ineligible industries and non-preferred industries. Ineligible industries must be approved by senior management. Non-preferred industries should be looked at with caution, and anything questionable should be reviewed by another member of the underwriting team. |

g. Industries

| Ineligible Industries | Non-Preferred Industries |
|---|---|
| Indian Tribes | Beauty Parlors & Hair Salons |
| Asbestos Products | Bowling Alleys |
| MEWAs, METs | Casinos |
| Professional Employee Organizations | Co-ops/Consortiums |
| Seasonal/temporary industries | Drinking Establishments |
| | Liquor Stores |
| | Logging, timber, and sawmill-related companies |
| | Long Haul Trucking |
| | Meat Packing and Processing |
| | Strip Mining |
| | Underground mining |
| | Municipalities (government entities) |
| | Schools and school districts |

h. Hospital Groups
    i. With hospital groups, the employer is the insured and possibly the health care provider. Because of the control over what care occurs and where it occurs, domestic charges are covered on a limited basis.

| |
|---|
| Current experience must state what the domestic reimbursement is x%. |
| For groups increasing or decreasing their domestic reimbursement percent, you must have the claims experience broken out between foreign and domestic. |
| Tertiary Hospitals with more than 80% domestic reimbursement must be looked at with caution. |
| Determine the appropriate Domestic Hospital Rate Factor. Apply the DHRF in the manual adjustment section of the specific worksheet. |
| The Domestic Hospital Rate Factor may not be applicable to some Specialty Facilities such as Children's Hospitals or Psychiatric Hospitals. |
| SIC for Clinics can be adjusted to 1.05 adjust load factor. |

i. Contract Changes
    i. Employers currently self-funded with a 12/12 or run-in contract and wishing to renew on a 12/12 or run-out contract must sign a disclosure statement indicating they understand the risk associated with a coverage gap.

ii. Exhibit A Disclosure Acknowledgment

## 5. Specific Stop Loss Coverage Parameters

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| Specific deductible levels ranging from $50,000 and above can be quoted. |
| Specific deductible should be between 2.5% and 15% of the Aggregate Expected Claims for deductibles < $100,000 and between 0% and 15% for deductibles >= $100,000. |
| On specific deductibles > = $100,000, the industry adjustment can be removed. |
| Specific annual and lifetime maximum is unlimited. |
| Underwritten policies must produce a minimum of $100,000 annualized Gross Written Premium<br>• Gross Written Premium is inclusive of Specific and Aggregate premiums |
| On first year cases, medTRANS may laser individuals based on the assumed ongoing risk of the claimant (see "Underwriting for Known Risk" section on page 8). |
| The underwriter's thought process should be documented. |

a. Specific Premium Adjustment Factors for non-traditional contract periods

| Deductible | 6 Mos | 9 mos | 12 mos | 15 mos | 18 mos |
|---|---|---|---|---|---|
| $25k - $50k | 77% | 92% | 100% | 108% | 118% |
| $50k - $100k | 74% | 92% | 100% | 110% | 120% |
| $100k - $200k | 70% | 89% | 100% | 114% | 130% |
| $200k+ | 67% | 84% | 100% | 122% | 141% |

## 6. Underwriting for Known Risks

a. There are considerations that must be explored prior to releasing a bindable quote. The underwriter should have a strong handle on how the calculated premium rates would stack up against the employer's previous large claim experience. **The underwriter should also keep in mind that the specific premium calculation is designed to cover unknown large claim risk.** If the account is a new prospect, the following deliberation should take place.

b. The first step in the handling of a potential ongoing claim situation is to gather as much information on the individual as possible. Once the information has been gathered, the underwriter should consult with in-house medical management resources to review the data and use their evaluation as a tool in determining the future cost of this member(s). Once the underwriter and clinical department agree what the future risk is, there are several ways in which to underwrite this known ongoing risk.

   i. Exhibit B: Clinical Review Submission procedure

c. The underwriter, together with the Clinical Strategies department, have two options for known claimants expected to break the specific deductible.

i. **Exclusion of a claimant:** This is the most drastic way of handling an ongoing claim. If this option is chosen, we will make this statement part of our policy and issue an endorsement excluding the claimant(s) by name or unique identifier. Any claimant excluded from specific coverage will also be excluded from the aggregate coverage.

ii. **Individual Specific Laser:** This is the most widely used option and is done so by placing a separate, higher specific deductible amount on the claimant in question. We will make this part of the policy by including the laser on the Schedule of Excess Loss Insurance. **If more than 5% of the employee population qualifies for lasers, the proposal must be escalated to senior management prior to releasing the proposal.**

iii. **Conditional / Treatment-based laser:**

d. Adjustments to clinical reviews and laser directives initially set by the clinical staff may be needed from time to time, but not regularly. Underwriter discretion on clinical assessments should never exceed 10% of the projected risk, in either direction. Any adjustment scenario is to be considered the exception vs the norm.

e. If there is aggregate coverage, only eligible expenses up to the general policy-specific loss limit will be eligible to apply to the aggregate. The aggregate loss limit equals the aggregate deductible amount for all (non-lasered) participants incurring claims under the specific loss limit.

f. **Increasing the entire group's specific retention:** This is a way to handle an ongoing claim without singling out any individual(s). You can include the ongoing claim if you raise your group's specific retention amount to a level that will cover more of the expected cost of the ongoing claim (frequency of high-cost claimants should be considered to determine the appropriate spec level).

g. **Building the amount of the ongoing claim into the premium**: This is yet another way to handle an ongoing claim without singling out any individuals. Once we evaluate the risk, we determine a laser and then convert that additional risk into a premium. The projected premium adjustment will be for the assessed clinical volume(s) in addition to expense loads (S,G & A) required to be paid out on any submitted premium volume. Adjustments to clinical reviews and laser directives initially set from the clinical staff may be needed from time to time, but not regularly. Underwriter discretion on clinical assessments should never exceed 25% (75% of the projected risk premium) with this scenario. Any adjustment scenario is to be considered the exception vs the norm. The disadvantage to this option is if the claim never materializes, you have still paid the premium.

## 7. Stop Loss Products

a. Specific Advance Funding

i. The specific advance funding option is offered to all groups. This product provides groups with cash flow assistance. **<u>This product option is offered as a courtesy at no additional charge</u>**.

ii. Specific advance funding on specific stop loss claims is available to employers for covered expenses upon meeting all the requirements listed below:
    1. The specific deductible ***must*** be paid in full by the policyholder prior to any claims being considered for advance funding.
    2. The claim amount must be equal to or greater than $1,000.
    3. Claims submitted for advance funding must have been fully processed according to the terms of the Plan by the Administrator and must be ready for payment.
    4. Normal specific claim audit procedures will be implemented prior to any checks issued by medTRANS Insurance, Ltd.
    5. The employer's payment for covered expenses must be released, to the provider, within five (5) days of receiving the reimbursement check by medTRANS Insurance, Ltd. If these payments are not made within five (5) days, the reimbursement check must be returned to medTRANS Insurance, Ltd
    6. Any portion of the reimbursement check not used to reimburse covered expenses, due to additional discounts or any other reason, must be returned to medTRANS Insurance, Ltd within five (5) days.

b. Aggregating Specific Option (*not currently offered by medTRANS*)
    i. The aggregating specific option is a product variation that may be attractive to an employer who is looking to assume a fixed amount of additional risk beyond the stated individual specific retention. This fixed amount varies by employer group and is determined during the underwriting process. As with any variation from the normal stop loss product, the TPA should make sure the employer understands the risks and rewards associated with it.
    ii. The aggregating specific option lowers the rate of the specific premium by creating an additional employer liability pool. This additional pool of risk is the employer's risk. As mentioned previously, this pool is a fixed dollar amount and sits on top of the employer's underlying specific deductible. Once an individual on the employer's plan reaches the underlying specific deductible, the employer will continue to be on risk for the claim until the pool has been exhausted. Once an individual or a combination of individuals have met their specific deductible(s) and the dollars exceeding the deductible(s) has exhausted the additional risk pool, the stop loss carrier begins to pick up the liability. The following example should help clarify how the product works:
        1. Specific Deductible = $100,000
        2. Aggregating Specific Deductible = $60,000

| | Claimant 1 | Claimant 2 | Total |
|---|---|---|---|
| Claims Paid to Providers | $132,000 | $209,000 | |
| Specific Deductible | $100,000 | $100,000 | |
| Specific Claim amount | ($32,000) | ($109,000) | $141,000 |
| Employer Liability | $32,000 | $28,000 | ($60,000) |

| | | | |
|---|---|---|---|
| Stop Loss Carrier | | | $81,000 |

iii. In the above example, we can see the first claimant used up $32,000 of the $60,000 pool. The second claimant used up the remaining $28,000, and the stop loss carrier will pick up all additional dollars that penetrate the specific deductibles.

iv. The pricing for this product is done as follows:

1. Determine the appropriate annualized premium (including expenses load) at the underlying specific deductible.
2. Subtract the aggregate pool amount from the annualized premium.
3. The remaining amount is the payable specific premium.

v. Careful consideration should be given when: any aggregate pool amount is greater than 50% of the net/net annualized premium or when the aggregate pool is not more than 90% of the lowest experience year (experience is annualized and trended).

c. medTRANS' 2x, 4x, 6x method to assign Known high-cost claimants

i. In response to the stop loss market's "No New Laser/Renewal Rate Cap" offers, medTRANS Insurance Ltd offers 2nd and subsequent year renewals a means to mitigate the cash flow risks of a developed or developing high-cost claimant(s), expected to breach the specific deductibles in the next renewal policy period.

1. When a high-cost claimant is discovered, the insured has the option to either accept the full LASER value it has earned OR
2. Accept a method to have their captive and possibly other captives finance a portion of said earned LASER.
3. If the insured's current specific deductible is $50,000 and a known high-cost claimant is expected to cost in the next policy period, $450,000, the insured can either accept the full LASER or engage the 2x LASER limit feature. This means the maximum LASER value offered to the insured is 2 times their current specific deductible. In this case $100,000.
4. If the same high-cost claimant remains on the plan, the next year provision allows for the policy to issue a LASER at 4 times their specific deductible. In this case, $200,000.
5. If the same high-cost claimant remains on the plan in the 3rd renewal, the provision provides for a maximum LASER of 3 times the current specific deductible. In this case, $300,000.
6. If the same high-cost claimant remains on the plan in the 4th renewal, there are no longer limits on the LASER value for this claimant. In this case, if this claimant is expected to cost $500,000, a LASER will be issued for $500,000.

7. In addition to the 2x, 4x and 6x, medTRANS Underwriting will apply an additional 20% premium load maximum increase each year the insured opts to engage this feature.

## 8. Aggregate Stop Loss

### a. Aggregate Stop Loss Parameters

i. Aggregate maximum benefit is limited to $1,000,000.
ii. The standard corridor is 125%. A corridor below 120% will require review of the Director of Underwriting.
    1. The review will produce a report back to the medTRANS Insurance Finance Committee
iii. **NOT APPLICABLE TO medTRANS underwriting at the moment**. For new business, all run-in contracts (15/12, 18/12, 24/12 and paid) require a run-in limit set at 15% of the attachment point. Removal of the aggregate run in limitation can be considered if pended and denied reporting is provided. Extra caution should be employed if there is a change in administrators.
iv. **NOT APPLICABLE TO medTRANS underwriting at the moment**. For renewal business, a run-in limit is recommended when changing the Third-Party Administrator.
v. For run-out contracts, cases that terminate prior to the end of a contract period do not receive run-out protection.

b. **Aggregate Adjustments for Contract Periods**

i. Any policy period that is less than or greater than 12 months must be reviewed by the Director of Underwriting
ii. Policy periods less than 9 months or greater than 12 but less than 15 months will be looked at on an exception basis only and must be approved the Director of Underwriting.
    1. Under no circumstances will a policy be allowed to be issued with greater than 15 months of coverage.
iii. A suggestion should be made to the group to stay on a 12-month contract. The group could terminate the 12-month contract early and start over on a new contract to coincide with the new effective date desired. If the group's claims are close to or already penetrating the specific deductible, the group could
iv. choose to not terminate early.

c. Experience and Enrollment

i. In order to bind a medical stop loss policy:
    1. Claims through 9$^{th}$ months &
    2. A minimum of 24 months of verified experience.

ii. If monthly enrollments per year have increased more than 50%, lag enrollment a minimum of 3 months.
iii. For new business and renewals, cases may be finalized with 9 months of current years' experience. But 12 months of experience will be required if any of the following has occurred:
    1. There has been significant growth
    2. Incomplete prior year's claims (missing 11th and 12th month)
    3. Evidence of claims dumping prior year
    4. Claims trending over 50% current year
    5. or change in TPA.
iv. If the final two months of paid claims result in an increase of 7% or greater than the previously quoted factors, the aggregate factors should be adjusted accordingly.

d. Manual Aggregate
    i. Hospitals, schools, municipalities, non-preferred industries, and ineligible industries do not qualify.
    ii. No straight manual aggregate is available on currently self-funded cases, as experience should be available. Exceptions include spin-offs, mergers, HMOs.
    iii. Recommended corridor is 125% of expected paid claims.
    iv. A comparison should be made between the self-funded cost and the fully insured cost.
    v. Disclosure will still be necessary. If shock loss information is unavailable, recommend requesting health statements.

## 9. Aggregate Stop Loss Products

a. Monthly Aggregate Accommodation
    i. The monthly aggregate Accommodation is designed to assist smaller self-funded employers with cash flow during the policy period. Instead of reimbursing aggregate claims at the end of the policy year, this product feature will provide a monthly reimbursement in the event the year-to-date paid claims exceed the year-to-date aggregate attachment point. The employer is expected to reimburse the stop loss carrier if, in the months subsequent to a monthly payout by the stop loss carrier, the employer's year-to-date paid claims dip below the year-to-date attachment point. The following are some guidelines associated with this option:
        1. Groups up to 250 lives are eligible, and it is available for groups > 250 lives if specifically requested.
        2. The minimum reimbursement is $1,000.

# 10. Definitions

### Aggregate Corridor

The margin above the expected claims level within which the employer retains financial responsibility under an aggregate stop-loss policy. It is typically expressed as a percentage (e.g., 125%). medTRANS requires special approval for corridors under 120%.

### Aggregate Stop Loss

A stop-loss insurance product that protects the employer against the cumulative cost of claims that exceed a defined attachment point for the entire group over the contract period. It serves as a financial safeguard against unexpectedly high total claims volume.

### Attachment Point (Aggregate)

The dollar threshold of total eligible claims that must be exceeded before aggregate stop-loss benefits begin. Calculated based on historical claims, enrollment, and expected trends.

### Claimant

An insured individual whose incurred medical claims are submitted to the stop-loss policy for reimbursement. Claimants who have breached or are expected to breach the specific deductible are subject to special underwriting scrutiny.

### Contract Period

The length of time for which stop-loss coverage is issued. While 12 months is the standard, medTRANS evaluates non-standard terms (e.g., 9-, 15-, or 18-month periods) on a case-by-case basis and may apply adjustment factors accordingly.

### Deductible (Specific)

The dollar amount the employer must pay for a covered individual's claims before the specific stop-loss coverage begins to reimburse. This amount varies by group size, industry, and underwriting risk. Lasers may be applied for high-risk individuals.

### Disclosure Statement

A formal document signed by the employer acknowledging the risks of certain policy structure changes, such as shifting from a 12/12 to a run-out contract. It ensures informed consent to any exposure gaps.

### Domestic Hospital Rate Factor (DHRF)

An actuarial adjustment applied to manual rates when a significant portion of claims are reimbursed through affiliated or "domestic" hospital systems. Required for hospital groups with >80% domestic utilization.

### Experience Period

The timeframe for which claims, rate history, and enrollment data are reviewed to assess underwriting risk. A minimum of 9 months is required, with 12 months preferred in cases involving volatility, growth, or incomplete historical data.

### High-Cost Claimant

An individual whose claims are expected to significantly exceed the standard specific deductible, either based on prior experience or clinical projections. These claimants may be subject to lasers, exclusions, or premium surcharges.

### Laser

A specific underwriting tool used to assign a higher individual deductible to a known high-risk claimant. Lasers are disclosed in the policy and may be applied at initial issuance or renewal. Lasering helps limit exposure to extraordinary claimants without impacting the group's base deductible.

### Manual Aggregate

A method for calculating an aggregate attachment point in the absence of sufficient claims experience. Used selectively for new entities, spin-offs, or where credible data is unavailable. Ineligible for certain high-risk or preferred industries.

### Minimum Participation Requirement

A coverage eligibility standard requiring a minimum percentage of eligible employees to enroll in the health plan: 75% for contributory plans and 100% for non-contributory plans. Deviation from these benchmarks may trigger escalated underwriting review.

### Monthly Aggregate Accommodation

A feature that enables interim reimbursements on aggregate claims exceeding year-to-date attachment points, offering cash flow relief during the plan year. Requires reconciliation at year-end and potential repayment if claims subsequently fall below the aggregate threshold.

### Run-In Claims

Claims incurred prior to the start date of the stop-loss policy but paid during the policy period. Subject to defined limits (e.g., 6 months) and require disclosure and validation.

### Run-Out Claims

Claims incurred during the stop-loss policy term but paid after the term has ended. A run-out period of up to 24 months may be available, depending on contract structure.

### Specific Stop Loss

A core stop-loss product that limits an employer's liability on individual claimants. Reimburses the plan for eligible claim amounts exceeding the specific deductible on a per-

member, per-contract-year basis. Provides protection from catastrophic individual health events.

### Specific Advance Funding

A policy feature allowing reimbursement of specific claims prior to the employer's payment to the provider, subject to eligibility and audit. Intended to alleviate short-term cash flow burdens and only available under designated conditions.

### Underwriting for Known Risk

A deliberate process for evaluating and pricing stop-loss coverage for groups with known high-cost members. May include collection of clinical data, coordination with medical management, and application of exclusion riders, lasers, or premium loadings. medTRANS uses structured scenarios (e.g., laser, exclusion, aggregate accommodation) to address such risk equitably and transparently.

### 2x/4x/6x Laser Renewal Structure

A proprietary underwriting method used to phase in increasing specific deductibles (lasers) for recurring high-cost claimants across successive renewals. This limits the immediate financial shock to the employer while ensuring premium alignment with actual risk exposure over time.

## 11. Related links and resources

a. Exhibit A: Disclosure Acknowledgement
b. Exhibit B: Clinical Review Submission Procedure
c. Exhibit C: Broker Conflict Attestation


Exhibit A: Disclosure Acknowledgment

# Disclosure Acknowledgment – Transition in Contract Basis

RE: Stop Loss Contract Type Change – 12/12 or 15/12, aka "Run In" or "Paid" to 12/15 or 12/18 aka "Run-Out" term.

This notice serves to inform the policyholder of important considerations associated with the transition of the stop loss policy contract basis from a run in, to a 12/15 or 12/24 or another form of run-out contract term.

## Contract Definitions:

- 12/12 Contract: Covers claims incurred and paid within the same policy 12 month period.
- 12/15 Contract: Covers claims incurred within the policy year and paid within 3 months following the end of the policy year.
- Run-Out Contracts: Variants including 12/15, 12/18, Paid, etc., which provide post-policy period reimbursement for eligible incurred claims.

## Acknowledgment of Coverage Implications:

The policyholder acknowledges that the transition from a run-in contract to a run-out contract may result in a limited period during which certain claims may not be eligible for reimbursement under either the prior or the renewed stop loss policy. Specifically, this may apply to claims incurred prior to the effective date of the new policy period but paid after the effective date, depending on the structure and limitations of each policy term.

- The policy does not provide retroactive coverage for claims incurred outside the current policy's incurred period unless otherwise specified.
- Claims must meet both the incurred and paid requirements as defined in the applicable stop loss contract to be considered eligible for reimbursement.
- The determination of coverage is subject to all terms, conditions, limitations, and exclusions of the policy.

## Partial Resolution

To partially resolve the gap in coverage, medTRANS Insurance Ltd is willing to offer to reinsure a separate, run in policy term to the owner of the captive that participates in the medTRANS' risk pool. Policy premiums for the separate run in policy will be billed from Complete Captive

Management Services on behalf of the captive that issues the separate policy. The terms of this separate policy is as follows:

- Run in policy will be underwritten separately based on the insured's historical claims.
- The stop loss policy deductible will reset on the policy's effective date.
- This means the employer will be responsible for funding claims up to the stated deductible incurred by the employee during the term of the policy.
- Policy coverage will be incurred 3 months prior to the effective date and paid within 3 months of the effective date.

## Policyholder Statement:

By signing below, the policyholder confirms that they have reviewed the stop loss contract options and understand the implications of transitioning to a different contract basis. The policyholder accepts responsibility for any potential uninsured exposure that may result from this change.

Authorized Representative: _____

Name: _____

Title: _____

Date: _____

Exhibit B: Clinical Review Submission procedure

# Clinical Review Procedure

Issued by: Director of Clinical Strategy, medTRANS Insurance Ltd.

## 1. Purpose

To provide a consistent, structured approach for evaluating clinical risks associated with employer groups applying for a Proposal-level stop loss quote. This procedure aims to project future expected costs related to high-cost disease states and guide underwriting decisions in alignment with medTRANS' risk philosophy.

## 2. Scope

This procedure applies only to groups progressing to the Proposal stage of stop loss underwriting. It does not apply to groups requesting:
- Illustrations (non-binding and for demonstration only)
- Indications (preliminary quotes missing minor data)

Only Proposal-bound groups will undergo a clinical risk assessment, to streamline resources and avoid unnecessary workload on the Clinical Strategy team.

## 3. Clinical Review Triggers

A clinical review is initiated by the Underwriting Department when:
- A group has met all threshold underwriting requirements.
- Known high-cost claimants are present or expected.
- A proposal (binding quote) is being developed.

The review will not be conducted if only an Illustration or Indication is being requested.

## 4. Required Clinical Data Elements

To begin a clinical review, the following must be provided:
- Detailed claimant-level claims history, particularly for those who have breached or are expected to breach specific deductibles.
- Prescription claims reports for all subscribers.
- Prior and current high-cost claimant profiles.
- Monthly claims experience, including medical and pharmacy claims.
- Diagnosis and treatment plans for high-risk individuals (if available).
- Previous lasers or exclusions applied by prior carriers.

## 5. Review Methodology

The Clinical Strategy team will:

1. Analyze Disease States – Identify high-cost or chronic conditions (e.g., cancer, ESRD, hemophilia, neonatal ICU, transplant).
2. Forecast Future Costs – Utilize clinical databases, cost predictors, and historical trends to project cost ranges for each high-risk claimant.
3. Consult with Underwriters – Present future cost estimates to underwriting for use in:
   - Laser assignments
   - Premium load considerations
   - Risk exclusions

## 6. Output of Review

Each clinical review will produce:

- A High-Cost Claimant Report with expected cost ranges.
- Recommendation(s) for one or more of the following:
  - Exclusion of individual(s)
  - Individual Laser with separate specific deductible
  - Premium Load based on future projected claims
  - Group-level Specific Deductible Adjustment (rare)
  - Decline to Quote (in case of unmanageable risk)

These outputs become formal inputs into the final underwriting decision.

## 7. Review Constraints and Escalation

- Adjustment limits: Underwriters may deviate no more than 10% from projected risk figures unless escalating to senior clinical staff.
- If >5% of group employees warrant lasers, escalate the case to Senior Management prior to releasing a proposal.
- Deviations beyond projected premium loads exceeding 25% must also be escalated.

## 8. Documentation and Tracking

- Clinical reviews and recommendations are archived with the group's underwriting file.
- Final underwriting decisions must clearly document how clinical input influenced the output.
- Re-reviews must be conducted for any claimant whose clinical trajectory has changed (e.g., remission, surgery success).

## 9. Confidentiality and Compliance

All data is handled under HIPAA and confidentiality standards. Only authorized personnel may access clinical submissions.