DESIGNED FOR HEALTH

Unparalleled insights into group benefits plans in Canada

Employers with less than 50 employees

Life's brighter under the sun

Sun Life Financial

Contents

I recently heard someone make the comment that "data is the new oil". Whether this is an overstatement or not, what is true is that the world is becoming an increasingly complex place and, more than ever before, access to high quality insight will separate leading businesses from the rest.

Group benefits plans are no exception. Knowing the latest trends in plan design, how a plan compares to industry peers and how employees are using their benefits will help design a winning plan - one that helps your Clients attract and retain talent and support the health and productivity of their employees.

As Canada's largest group benefits provider by market share, Sun Life has unprecedented insight into the Canadian group benefits space, drawing on data representing over 20,000 employers and several million employees and dependents.

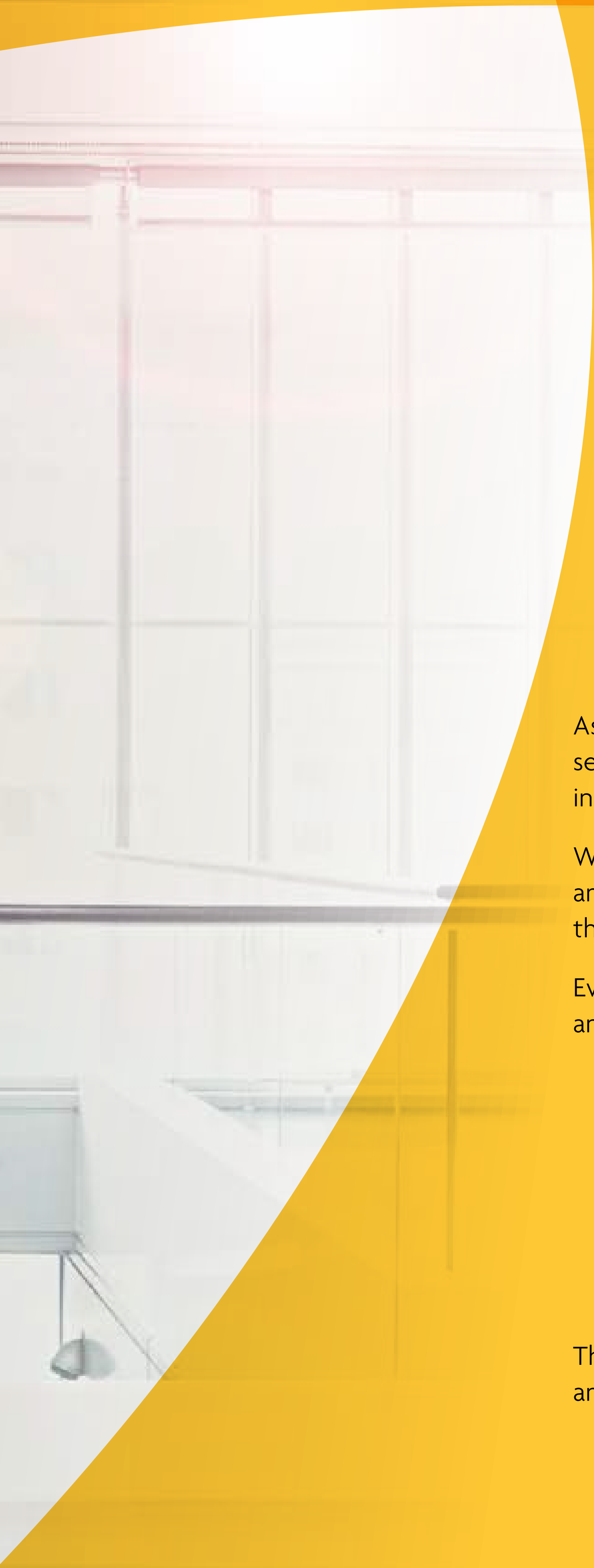
You'll find many more insights as you read on. Is the first of its kind in Canada. It brings you a comprehensive view of group benefits in Canada, and can help you support your Clients in making the best benefits decisions possible.

Our goal is to help you support your Clients to achieve lifetime financial security and live healthier lives. We appreciate the opportunity to be of service, and hope that you find the information and analysis in this report to be both insightful and helpful in assisting your Clients and enhancing your business success.

Sincerely,

Dave Jones
Senior Vice President Group Benefits
Sun Life Financial

PLAN DESIGN



As Canada's leading provider of group benefits plans by market share, we've seen it all when it comes to plan design, from the most traditional plans to innovative flexible benefits arrangements.

Why does plan design matter? In short, plans are an important investment for an organization and the right design helps ensure the most value is attained for the dollars spent.

Every workplace is different. By tailoring a benefits plan design to a workforce and organization's goals, you can:

- Better meet the health needs – and benefit preferences – of employees
- Increase employee productivity and engagement, as well as their perceived value of the plan
- Attract and retain talent
- Ensure the plan is financially sustainable, with appropriate cost and fraud controls in place

There are many design elements that can be used to meet employee needs and accomplish organizational goals. These include:

- The use of benefit choice and flexibility for employees
- The use of co-insurance, deductibles and maximums to control costs and encourage a "consumer-mindset" in terms of benefits usage
- Drug plan designs – such as the use of mandatory generic drug requirements – that balance the need of employees for comprehensive coverage, with the need of organizations for plan sustainability

Plan design matters, and this report has information that can help inform your plan design choices.

Paramedical coverage

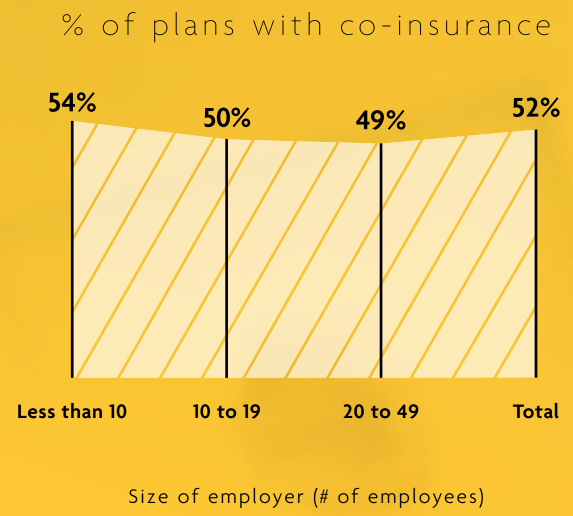
Most group benefits plans cover paramedical service expenses on behalf of employees – but the levels of coverage and types of practitioners included varies.

Covered paramedical services are typically performed by licensed health care practitioners. These can include a wide range of providers, such as podiatrists, chiropractors, naturopaths, psychologists, registered massage therapists, physiotherapists, and more.

Co-insurance

Co-insurance is an effective cost containment tool that encourages a more “consumer approach” to health care. Since co-insurance requires that employees bear some of the cost, this often leads to a more judicious assessment by the employee of whether treatment is needed, and if so, to what extent and at what cost.

Approximately half of employers include co-insurance in their plans, with the plans of the smallest employers (less than 10 employees) somewhat more likely to have co-insurance than larger plans.

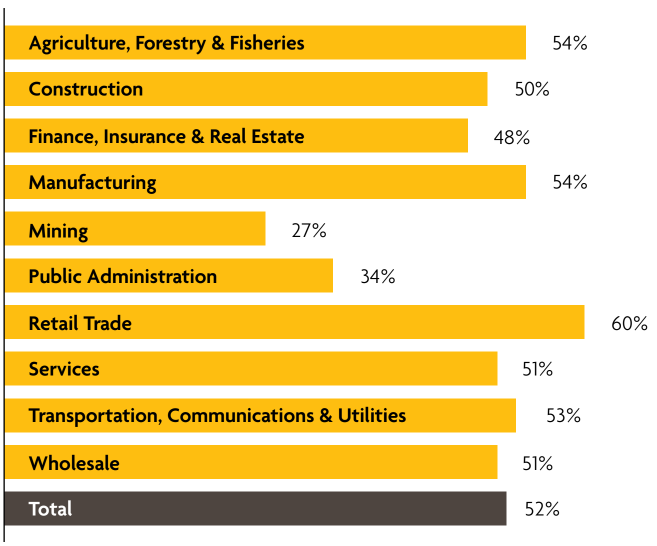


The incidence of co-insurance is fairly consistent across industries, with the exception of public administration and mining. The lower use of co-insurance in the public administration sector could reflect historical practices that are built into collective agreements, as much of the public service is governed by these agreements. Meanwhile, the mining sector's use of strong compensation packages, including rich benefit plans to attract and retain the skilled workforce required in industries such as oil and gas extraction could account for the lower incidence of co-insurance.

Among those plans with co-insurance, the most prevalent level of employer coverage is 80%. This is consistent across plan size and industry.

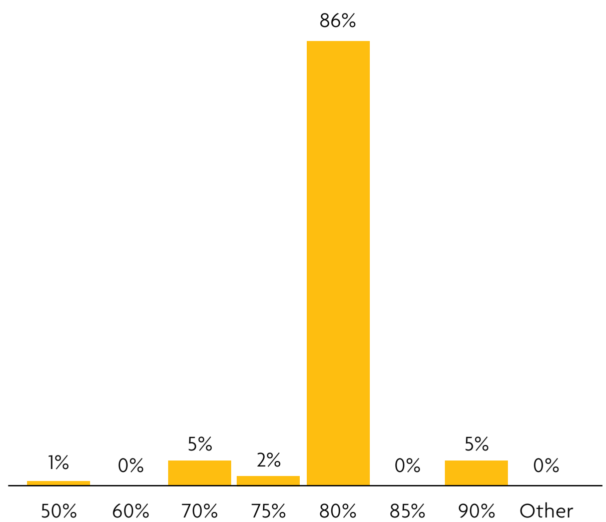
In terms of encouraging a more consumer approach to health care, this level may strike a good balance, resulting in employees having enough of a stake without being overly burdened by cost. The idea is that the employee-paid portion is low enough that they won't be discouraged from seeking the treatments they need, but high enough to discourage misuse of the benefit.

% of plans with co-insurance



Employer industry – Standard Industrial Classification System (SIC)

Frequency of co-insurance levels



Co-insurance (%)

Frequency of co-insurance levels

	<80%	80%	>80%
Agriculture, Forestry & Fisheries	8%	88%	4%
Construction	7%	89%	4%
Finance, Insurance & Real Estate	7%	88%	5%
Manufacturing	12%	81%	6%
Mining	2%	90%	8%
Public Administration	10%	74%	16%
Retail Trade	10%	86%	4%
Services	8%	86%	5%
Transportation, Communications & Utilities	9%	86%	5%
Wholesale	10%	84%	6%
Total	**9%**	**86%**	**5%**

Employer industry - Standard Industrial Classification System (SIC)

Deductibles

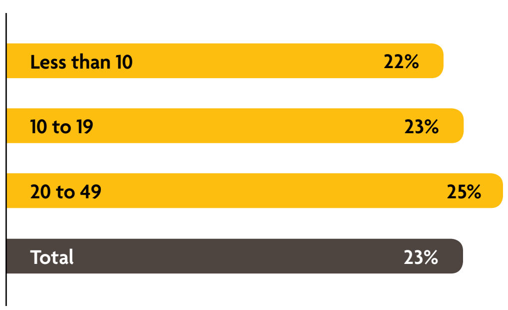
A deductible is a fixed dollar amount of eligible health care expenses that an employee must bear the cost of first before the plan begins to reimburse eligible expenses.

While deductibles are another way of managing costs, they are used far less frequently in plan designs than co-insurance. This could be for a number of reasons:

- Employers believe co-insurance is a more effective way of managing costs
- Deductibles add an extra layer of complexity to plan rules, and may be more difficult to communicate
- Deductibles may be perceived as a negative by employees, as they must pay something first before the employer pays anything
- Deductibles typically apply at the beginning of the plan year, and once satisfied, do not act as a cost containment motivator, unlike co-insurance, which continues through with each subsequent incurred expense

Slightly less than one-quarter (23%) of plans overall require a deductible, compared to the 52% of plans that use co-insurance.

% of plans with deductibles



Size of employer (# of employees)

The mining sector stands out as having the lowest incidence of deductibles. This sector also had the lowest average incidence of co-insurance. Again, this may reflect the use of strong compensation packages, including rich benefits plans to attract and retain the skilled workforce required in the industries that make up this sector.

% of plans with deductibles

Agriculture, Forestry & Fisheries	19%
Construction	18%
Finance, Insurance & Real Estate	21%
Manufacturing	29%
Mining	8%
Public Administration	27%
Retail Trade	22%
Services	22%
Transportation, Communications & Utilities	27%
Wholesale	27%
Total	**23%**

Employer industry – Standard Industrial Classification System (SIC)

Plans with deductibles for paramedical expenses include both deductible amounts for individuals as well as families, in the case of employees who have dependents covered under their plan. The most common deductible amounts are $25 for individuals and $50 for families. This is true across plan sizes and industries.

Benefit year maximums

Benefit year maximums cap the amount that is reimbursed to each person covered under the plan (employees and dependents) for a given type of paramedical practitioner during the benefit year.

Benefit year maximums are present in almost every benefits plan and are another important cost control measure. They can also be a tool for the reduction and prevention of benefit plan abuse and fraud.

For plans with individual practitioner maximums – those that apply a maximum to individual provider types – frequencies are clustered around $500 (56%) and $300 (30%). This distribution pattern is very consistent across plan size. When looked at by industry, we can see that the public administration, mining, finance, insurance and real estate sectors stand out as likely to have a maximum individual benefit year amount of $500 or more.

Frequency of individual benefit year maximum amounts

Size of employer (# of employees)	**< $300**	**$300**	**$350**	**$400**	**$450**	**$500**	**> $500**
Less than 10	2%	32%	5%	4%	0%	55%	3%
10 to 19	2%	29%	5%	5%	0%	55%	4%
20 to 49	4%	23%	5%	4%	0%	58%	5%
Total	**2%**	**30%**	**5%**	**4%**	**0%**	**56%**	**3%**

	< $300	**$300**	**$350**	**$400**	**$450**	**$500**	**> $500**
Agriculture, Forestry & Fisheries	0%	35%	5%	4%	0%	54%	2%
Construction	2%	34%	5%	3%	0%	53%	3%
Finance, Insurance & Real Estate	2%	19%	5%	4%	0%	64%	5%
Manufacturing	3%	31%	4%	6%	0%	52%	3%
Mining	0%	26%	2%	2%	0%	65%	5%
Public Administration	3%	15%	6%	5%	1%	67%	4%
Retail Trade	3%	35%	4%	4%	0%	51%	2%
Services	2%	27%	5%	4%	0%	58%	3%
Transportation, Communications & Utilities	3%	33%	5%	3%	0%	51%	4%
Wholesale	2%	30%	5%	4%	0%	56%	3%
Total	**2%**	**30%**	**5%**	**4%**	**0%**	**56%**	**5%**

In terms of annual maximums by individual practitioner type, physiotherapist services have the greatest percentage with annual maximums of $500 or more, while podiatrist services have the greatest percentage of maximums below $300 annually.

Frequency of Benefit Year Maximums for selected paramedical practitioner types

	< $300	$300	$350	$400	$450	$500	> $500
Acupuncturist	2%	30%	5%	4%	0%	55%	3%
Chiropractor	11%	14%	10%	9%	2%	33%	20%
Massage Therapist	2%	30%	5%	4%	0%	55%	3%
Naturopath	2%	30%	5%	4%	0%	55%	3%
Physiotherapist	3%	7%	2%	2%	0%	18%	68%
Podiatrist	63%	0%	0%	0%	0%	25%	13%
Psychologist	4%	18%	4%	3%	0%	67%	5%
Total	**2%**	**30%**	**5%**	**4%**	**0%**	**56%**	**3%**

Many plans combine two or more paramedical practitioner types and apply a **combined maximum** for that group. Groupings can vary a great deal across plans, with related services often grouped together. For example, chiropractic is often grouped with massage therapy and/or osteopathy.

Combined maximums are often greater than the amounts offered by plans with maximums for individual practitioner types, although many plans do have a combined maximum of $500, a maximum dollar amount that is also common for plans with individual practitioner maximums.

Raising mental health practitioner maximums to support employee mental health

The impact of mental health issues is a growing concern in the workplace. Each week, 500,000 Canadians miss a day of work due to mental health reasons[1] and Canadian employers have identified mental health as a leading cause of both short-term and long-term disability claims in their organizations.[2] As a preventive support to address this challenge some employers are increasing their maximums for psychological treatments as the typical coverage maximums often are only enough to pay for two or three sessions with a practitioner. Out-of-pocket costs are likely a significant barrier for many employees to access the mental health services they need.

Starbucks made the news in 2016 when it increased its annual maximum for psychological counselling to $5,000 per year, and some Canadian insurers, including Sun Life Financial, have increased their psychological services maximums to $10,000 or more per year for their employees.

[1] Mental Health Commission of Canada
[2] Towers Watson, 2009/2010 Staying@Work Report

HSA 101

Health Spending Accounts (HSA) are provided to employees to use for reimbursement of eligible health related products and services (examples include dental, drug and paramedical expenses such as chiropractic or massage therapy). Most HSA plans claims are non-taxable to employees (except in Quebec) and a business expense deduction for employers.

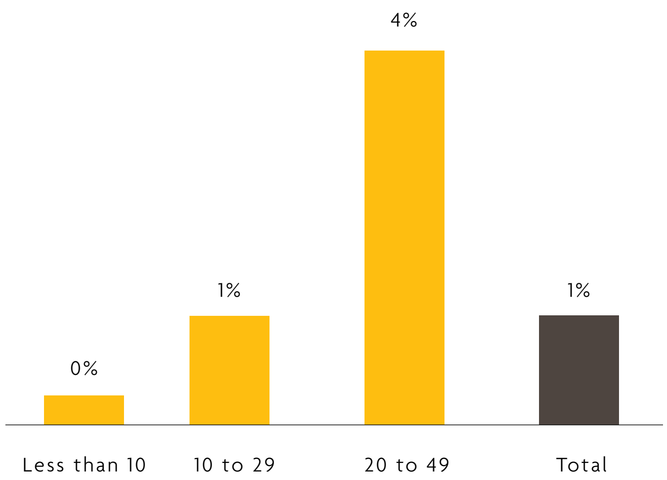
Health Spending Accounts

Health Spending Accounts (HSAs) are a way to add flexibility and choice to benefits plans. Once employees have the core protection they need, spending accounts provide employees with an added element of choice to purchase products and services to suit their needs and preferences. As the employer defines the spending accounts' credits available to employees, the costs to the employer are certain.

While many of Canada's largest employers include HSAs as part of their benefits offerings, the accounts are far less prevalent among plans of employers with less than 50 employees. This could be due to several reasons:

- the need to educate employees about the advantages of these accounts
- the desire of smaller employers to funnel available dollars to more traditional plans or benefits
- the inertia that comes from maintaining the plan design "status quo," as smaller employers may not have the internal resources to spearhead change

% of plans offering HSAs



In terms of industry adoption, HSAs are most common among plans in the mining sector. Over past decades, industries in this sector, such as oil and gas, have grown substantially with the world's commodity boom. Strong compensation packages, including rich benefits plans, have been used by employers to attract and retain the skilled workforce required in these industries – and an HSA account can be a way to "top up" a traditional plan.

	% of plans offering HSAs
Agriculture, Forestry & Fisheries	0%
Construction	0%
Finance, Insurance & Real Estate	2%
Manufacturing	1%
Mining	4%
Public Administration	0%
Retail Trade	1%
Services	1%
Transportation, Communications & Utilities	1%
Wholesale	1%
Total	**1%**

Employer industry – Standard Industrial Classification System (SIC)

Plan members are using their spending accounts to support their health, and that of their dependents, in a variety of ways. Employees tend to use their HSA to help pay for traditional, core benefits such as vision care, dental surgery and prescription drugs – supplementing coverage from their traditional or flex plans.

The Personal Spending Account

As an employer, you need to stay competitive. One way to attract top talent is by offering programs that provide employees with access to enhanced health and wellness solutions. With a Personal Spending Account (PSA), employers can offer more opportunities for health and wellness outside of their regular benefits plans or HSA.

Sun Life's PSA covers a wide range of eligible expenses to help employees live healthier lives, including gym memberships, athletic equipment, nutritional counselling, childcare expenses.

Our PSA is fully integrated into our digital platform, which allows employees to easily manage their accounts and submit claims through the my Sun Life Mobile app or through mysunlife.ca. This also makes administration easy for employers and since the employer allocates a specified amount of credit into each employee's account, employer costs are defined up front and don't change.

Prescription drugs coverage

Prescription drug costs continue to rise – and are the largest group benefits plan expense. With an aging population, and a pipeline of expensive but highly effective new drug classes emerging, many organizations face challenges in balancing drug plan sustainability with the needs of employees for effective coverage.

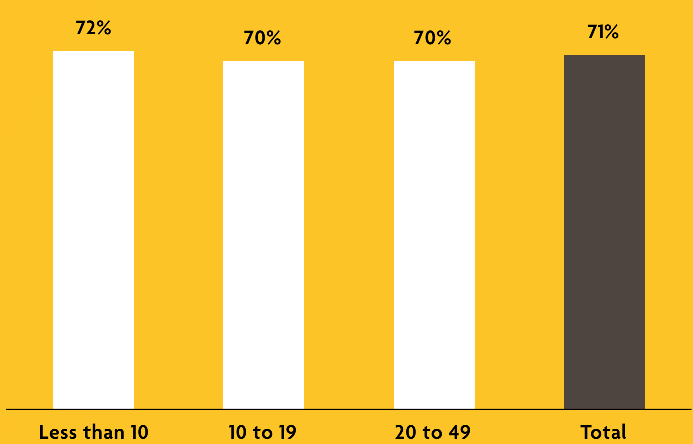
In the sections below, we highlight the prevalence of key elements of plan design that employers are using to balance the needs for comprehensive drug coverage and drug plan sustainability.

Co-insurance

As with paramedical benefits, co-insurance is a common part of drug plan design – used as a cost containment tool that can also encourage a more "consumer approach" to healthcare.

Seven out of 10 (71%) drug plans have co-insurance and, as is the case for paramedical benefits, the smallest plans are somewhat more likely to have this cost control feature.

% of plans with co-insurance



Employer size (# of employees)


Mr
Mrs
Miss
Address
For use only by
Pricing Office
Signature of Doctor

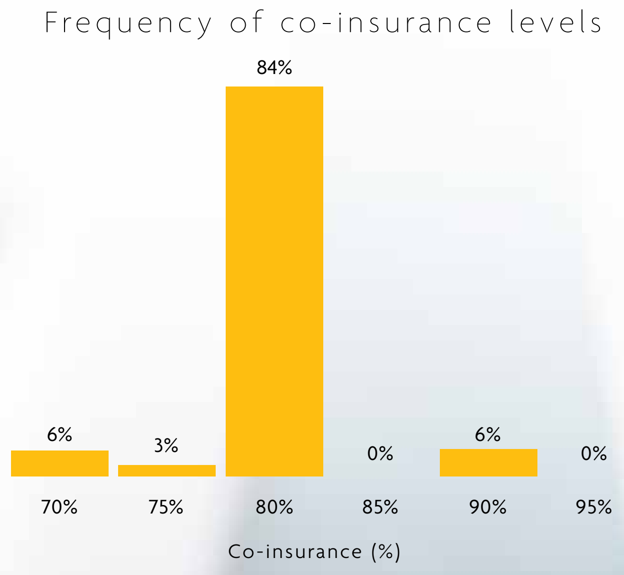
The prevalence of co-insurance across industries follows a similar pattern to that of paramedical benefits, with public administration and mining drug plans the least likely to have co-insurance.

% of plans with co-insurance

Agriculture, Forestry & Fisheries	75%
Construction	72%
Finance, Insurance & Real Estate	64%
Manufacturing	73%
Mining	54%
Public Administration	42%
Retail Trade	78%
Services	70%
Transportation, Communications & Utilities	75%
Wholesale	70%
Total	71%

Employer industry – Standard Industrial Classification System (SIC)

For drug plans that have co-insurance, the most prevalent level is 80% employer coverage. This percentage can be effective to encourage a more consumer approach to health care without creating a barrier to employees obtaining the drug therapies they need. The distribution of co-insurance levels across plan size and industries is consistent with that seen in the chart below representing all plans.

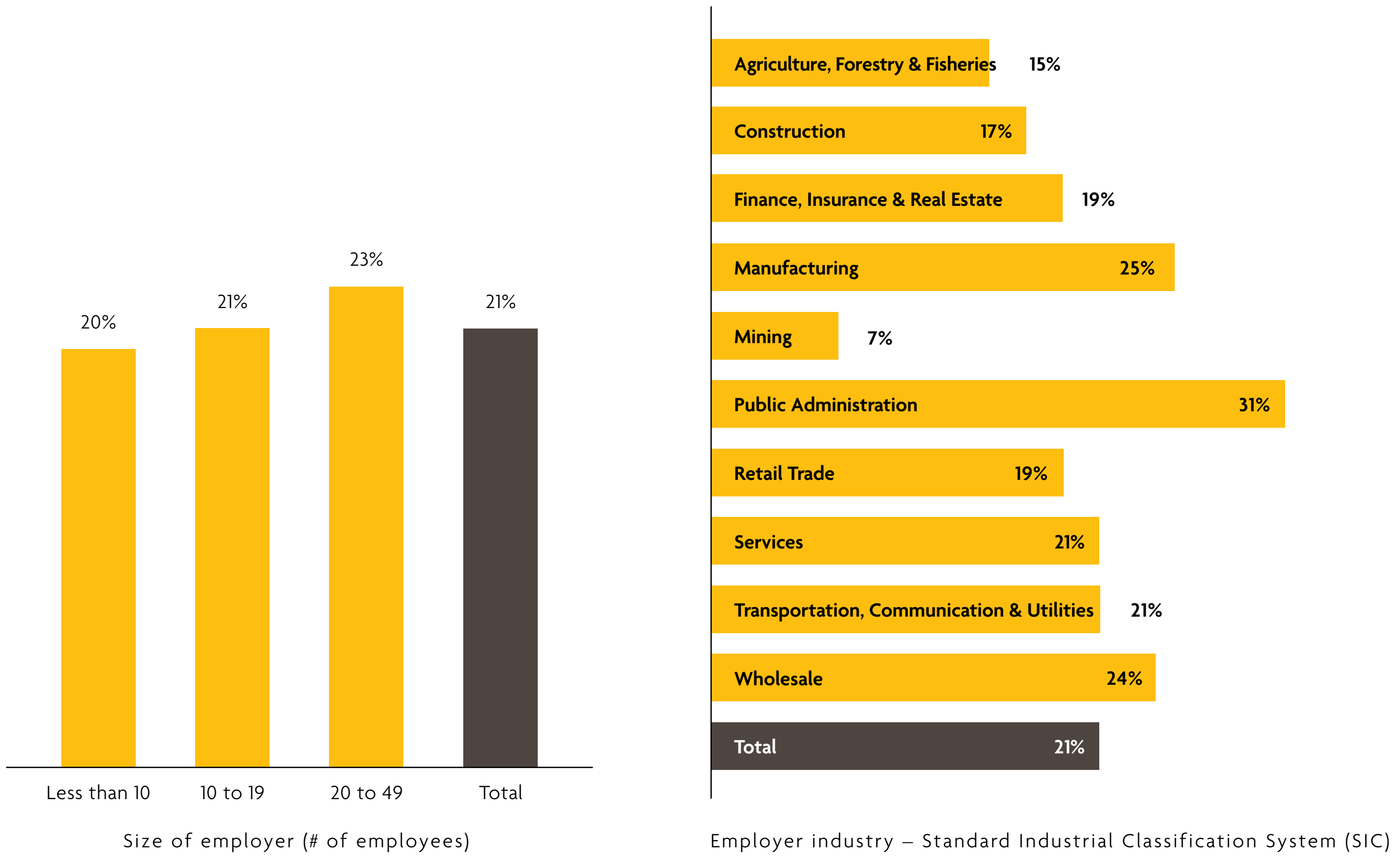


Deductibles

Similar to paramedical benefits, deductibles are used less frequently than co-insurance is in plan designs. Across plan sizes and industries, the majority of plans with deductibles set them at $25 or less for individuals and $50 or less for families annually.

The plans of larger employers are somewhat more likely to include deductibles. Consistent with the data for paramedical benefits, plans in the mining sector are least likely to include deductibles.

% of plans with deductibles



Keeping drug plan costs in check

Private drug plan costs in Canada are forecast to grow well beyond inflation in the coming years.[3]

An aging population and resulting increase in the incidence of chronic diseases, as well as new treatments for them, is driving growth in drug utilization. Meanwhile, with each year, more and more high-cost specialty drugs are entering the market, driving drug cost growth further.

Fortunately, there are many plan design features that can help offset increasing cost pressures on drug plans, without limiting employee access to effective drug therapies. Important plan features to consider are:

- Prior Authorization
- Preferred provider networks (PPNs)
- Managed formularies
- Generic substitution
- Dispensing fee caps

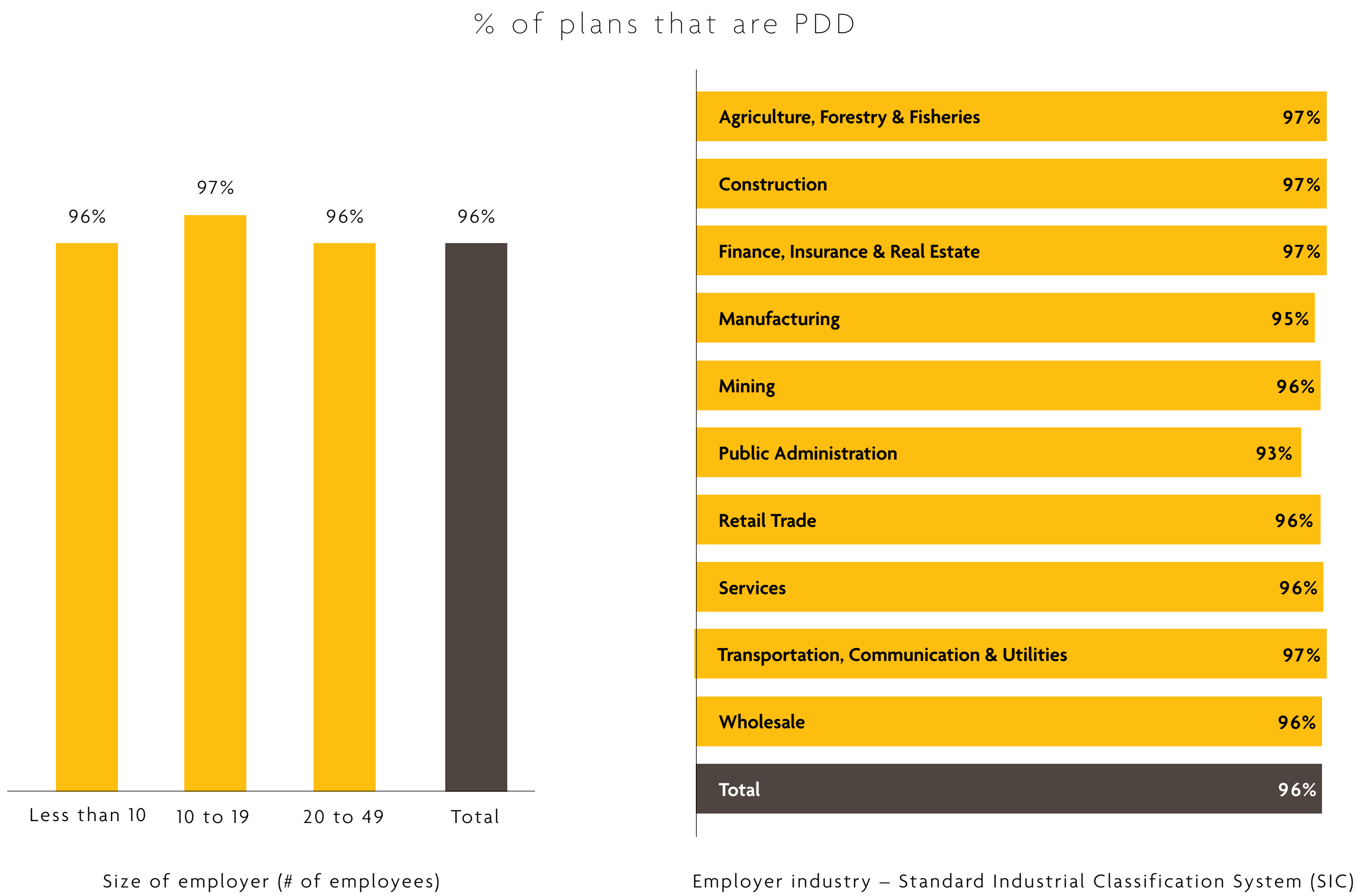
[3] Private Drug Plan Drug Cost Forecast (2016-2018) Research Provided by Quintiles IMS for Innovative Medicines Canada, The IMS Brogan File, Drug expenditure trends: 2014 vs. 2013

Pay Direct Drug Plans

Pay Direct Drug (PDD) plans allow employees to present a drug card at the pharmacy to have their drug claim processed instantly. The insurance carrier pays the claim to the pharmacy directly, the employee only needs to pay any deductible or co-insurance that applies to their coverage. Besides a fast and easy employee experience, PDD plans facilitate other important aspects of drug plan management:

- Ensuring that drug prices paid are reasonable & customary
- Dispensing fee management to limit high dispensing fees
- Cost management programs such as prior-authorization and preferred pharmacy networks to help protect long-term drug plan sustainability

Almost all plans are PDD plans across employer size and industry.



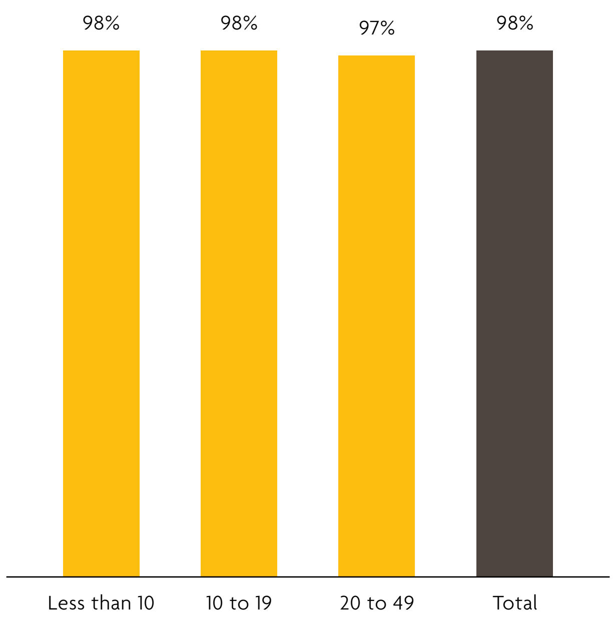
Prior Authorization

Prior authorization programs require that coverage for certain **specialty drug therapies** be pre-approved based on clinical criteria. If an employee is prescribed a specialty drug requiring prior authorization, the employee's prescribing doctor must complete a form to ensure that the patient meets the clinical criteria related to the specific drug.

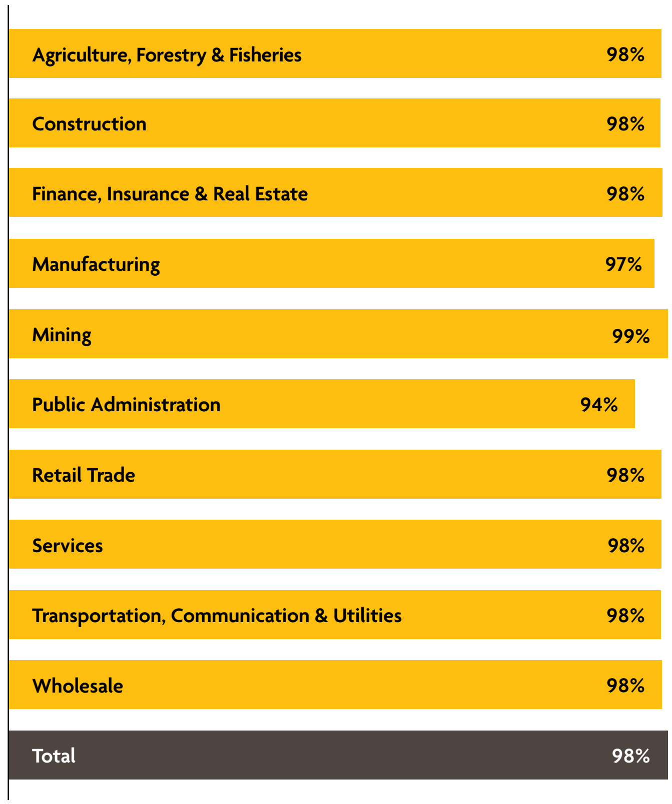
Prior authorization is an important plan design element to ensure that high cost drugs are pre-approved before beginning treatment. With the cost of many specialty drug treatments reaching thousands of dollars per year per claimant, prior authorization is an important cost control measure, ensuring that the member has access to the right drug, at the right time for the right indication.

Almost all plans of employers with less than 50 employees have prior authorization. This is due to prior authorization now being a standard feature of plans provided to smaller employers, where plan customization is less prevalent. Note that Sun Life plans must be Pay Direct Drug (PDD) plans in order to have prior authorization.

% of plans with prior authorization*



Size of employer (# of employees)



Employer industry – Standard Industrial Classification System (SIC)

*based on PDD plans

Preferred Pharmacy Network (PPN) for high-cost, specialty drugs

A Preferred Pharmacy Network (PPN) encourages the use of a network of select pharmacies that offer reduced drug costs and case management patient services.

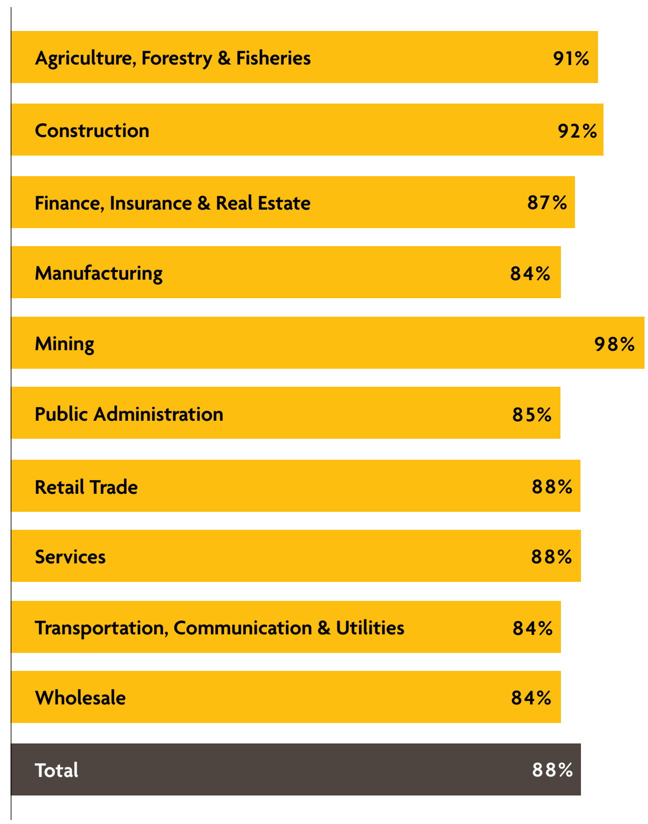
A key advantage of a PPN is lower markups on specialty drugs, negotiated by the benefits carrier with the pharmacy network. For employers, this can mean a decrease in the cost of claims, while employees can experience lower out-of-pocket expenses.

Services to help patients manage their medical conditions – such as education, counselling and help with navigating and applying for government and manufacturer financial assistance programs – are also a valuable part of the PPN model.

Note that Sun Life plans must have prior authorization in order to qualify for the specialty drug PPN. PPNs are not available in the Province of Quebec.

% of plans with specialty PPNs*

Size of employer (# of employees)



Employer industry – Standard Industrial Classification System (SIC)

*based on plans with prior authorization

Generic substitution

Generic drugs use the same active ingredients as brand-name products, but usually cost significantly less. Because generic drugs provide the same quality, purity and effectiveness of treatment, but at a lower price, they are a highly effective option for managing drug plan spending.

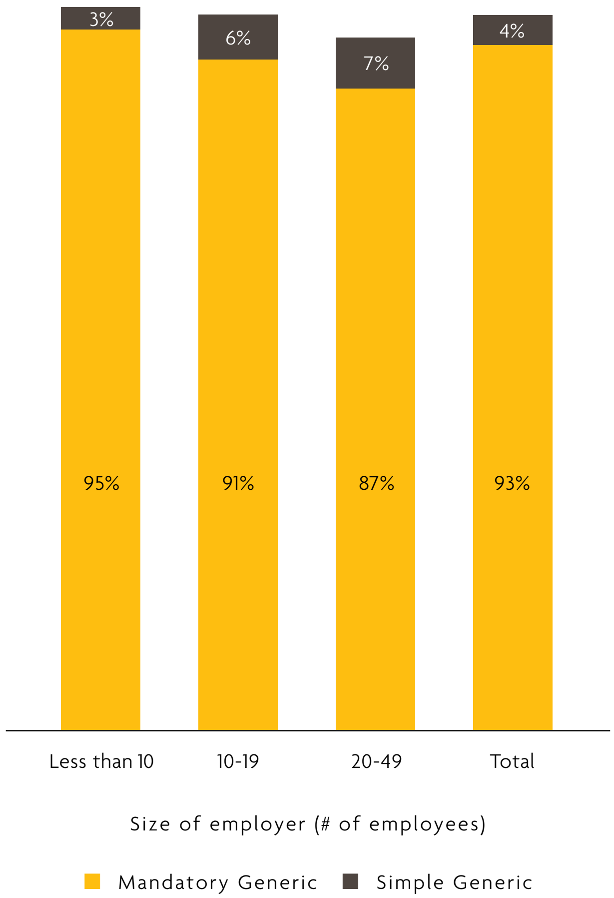
There are two types of generic substitution plan design features:

- **Simple generic substitution:** When a doctor prescribes a drug, the pharmacist will dispense the lowest priced equivalent (usually the generic version) of that drug, if one is available. However, if a physician writes "no substitution" on a prescription, the higher-cost drug can still be dispensed and covered under the plan.
- **Mandatory generic substitution:** As with a simple generic substitution plan design, when a doctor prescribes a drug, the pharmacist will dispense the lowest priced equivalent (usually the generic version) of that drug, if one is available. However, if a physician writes "no substitution" on a prescription, employees are required to pay the difference if the higher priced alternative is dispensed.

Similar to prior-authorization, generic substitution is now standard in the plans of employers with less than 50 employees. Overall, mandatory generic substitution is a feature of over 9 out of 10 plans.

Although much focus has been put on managing the cost pressures presented by high-cost specialty drugs, employers should not overlook the potential to make their coverage for traditional drug therapies the most efficient possible. Traditional drug therapies still account for approximately 70% of drug plan spend across Sun Life's block of business and generic substitution is an important strategy to ensure plans are getting the most from their traditional drug spend.

% of plans with generic substitution



Pharmacogentics: the future of drug prescribing is here

Pharmacogenetics uses information about an individual's genetic makeup to determine the drugs and doses that are likely to work best for that person. It helps identify genetic variations that influence the way a person responds to a particular medicine.

All that is required from the employee is a cheek swab or saliva sample. Results can be obtained from the lab and provided to their physician in a matter of days.

In 2017, Sun Life Financial became the first insurance carrier in Canada to announce a pharmacogenetics initiative by partnering with the Centre for Addiction and Mental Health (CAMH) and Assurex Health to join the IMPACT study – a large study of the application of pharmacogenetics in the area of mental health. Sun Life's partnership focuses on the study of pharmacogenetics testing for patients on disability leave due to a mental health condition.

There are many potential benefits of pharmacogenetics in group benefits – better health outcomes for employees, cost savings for the benefit plan and ultimately reduced costs related to absence and disability for the employer.

Managed formularies

A drug formulary is defined as a list of medications covered under a benefits plan. Under a managed formulary, coverage is restricted to a list of drugs chosen using criteria such as cost-effectiveness and therapeutic value. Managed formularies are designed to contain costs while still providing access to effective drug therapies.

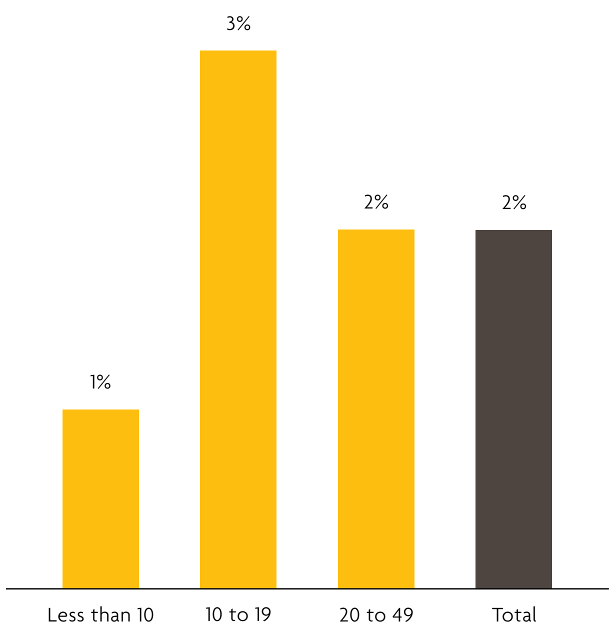
Managed formularies can differ by the criteria used to determine coverage, who performs the analysis and categorization as well as the number of coverage (co-insurance) tiers they are comprised of. This can allow the employer to achieve a balance between availability of therapies, cost control and user experience that is right for their organization and their benefits philosophy.

Combined with other plan design elements like mandatory generic substitution and prior-authorization, managed formularies can be a very important tool in helping keep drug plans sustainable.

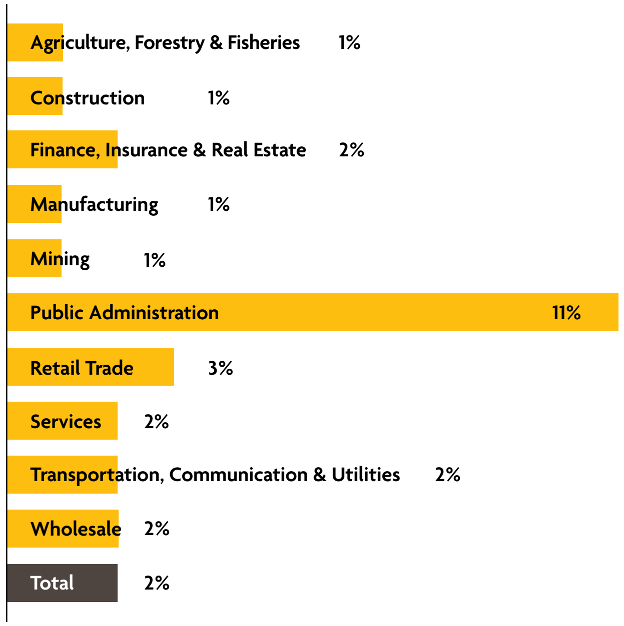
Managed formularies have been on the market for a while in the US and have gained in popularity. Relatively newer in Canada, the market has been fairly active in the past five years. For example, traditional managed formularies were considered “frozen” in time, while the new generation adapts when a brand name drug comes off patent or a new drug enters the market. Organization like TELUS Health and Shoppers Drug Mart have also entered the market and offer solutions to employers that can be added to their plan design.

Mostly popular in the plans of larger organizations, both unionised and non-unionised environments have adopted these strategies, however, adoption in plans of employers with less than 50 employees is still very low. With the increasing complexity of the pharmaceutical landscape and more and more high cost drugs coming to market, it is likely that the adoption of managed formularies will increase in plans of all sizes.

% of plans with managed formularies



Size of employer (# of employees)



Employer industry – Standard Industrial Classification System (SIC)

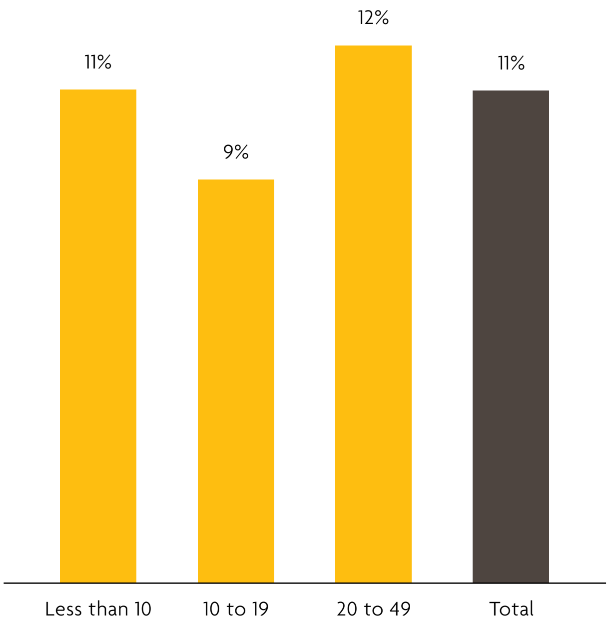
Dispensing fee caps

A dispensing fee is the fee charged for the professional services of the pharmacist when dispensing a drug. Dispensing fees vary from pharmacy to pharmacy – ranging from $4 to $14 or more, with a typical charge of about $10.

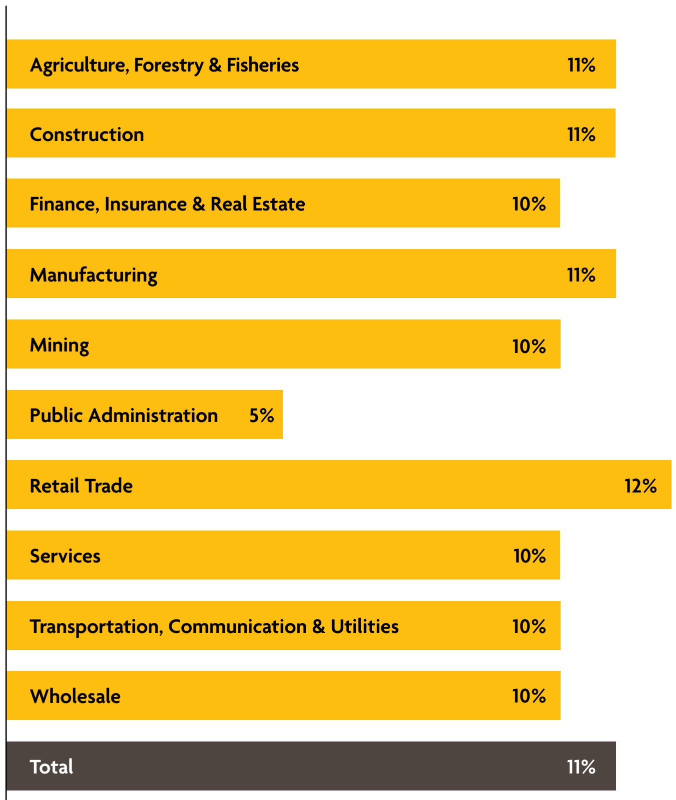
To help manage drug plan costs, plans can be designed to cap the dispensing fee reimbursement at a set dollar amount. This encourages employees to seek out pharmacies with lower dispensing fees, and to obtain larger, but less frequent, prescription refills for ongoing maintenance drugs taken to treat chronic conditions.

Dispensing fee caps have yet to gain significant adoption, with just 11% of plans including this feature. Public administration plans have somewhat the lowest incidence of this plan option. Note that dispensing fee caps do not apply in the province of Quebec.

% of plans with dispensing fee caps*



Size of employer (# of employees)



Employer industry – Standard Industrial Classification System (SIC)

*excludes plans based in the province of Quebec

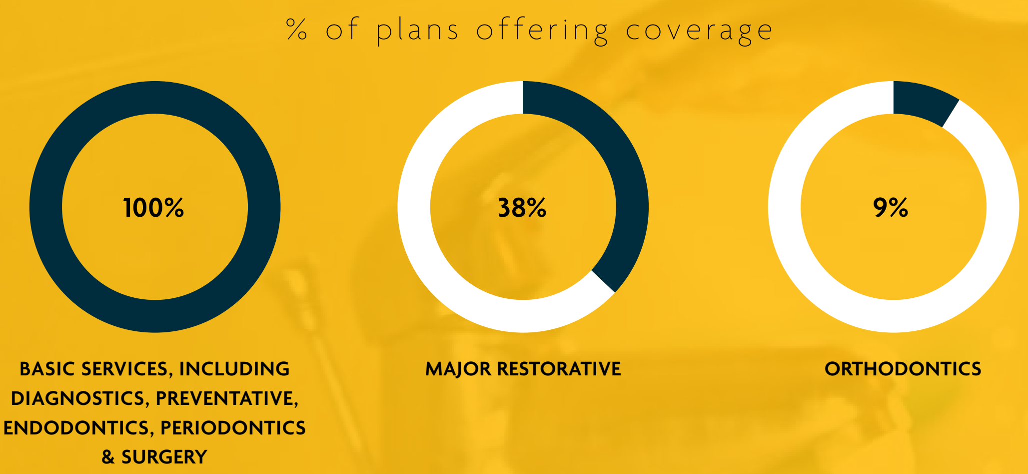
Dental coverage

Canadians rank dental plans as the most important benefit offered by employers. In our Sun Life Generations research[4] – a survey of 1,250 working Canadians from ages 18 to 65 – participants were asked to rank the importance of 10 workplace benefits. For every age group, dental benefits ranked highest, with 83% rating them as extremely or very important. This result outranked prescription drug coverage (79%), vision care (79%) and workplace retirement programs (76%), which were the next highest rated benefits.

Here is our dental plan design analysis, showing how employers in different industries and of different plan sizes structure their plans for this highly-valued benefit.

Dental services covered

Across plan sizes and industries, virtually all plans cover basic diagnostic and preventative services (including routine exams, cleanings, x-rays, flouride treatments and fillings), as well as surgical procedures such as tooth extractions, periodontic treatment (for gum disease) and endodontic treatment (for tooth work such as root canals).



[4] Conducted in 2016 by TNS Canada

Major restorative expenses – include crowns, bridges, dentures, and implants – are covered by about four in 10 plans, with larger plans more likely to offer this coverage. Plans in public administration and mining stand out as far more likely to offer major restorative coverage.

Overall, just 9% of plans offer coverage for **orthodontics** expenses for dependent children. Similar to major restorative expenses, with the plans of larger employers more likely to offer this coverage, as are plans in mining and public administration.

% of plans with coverage

Size of employer (# of employees)	Basic Services, including Diagnostic, Preventative, Endodontics, Periodontics & Surgery	Major Restorative	Orthodontics
Less than 10	100%	31%	4%
10 to 19	100%	46%	14%
20 to 49	100%	54%	23%
Total	**100%**	**38%**	**9%**

% of plans offering coverage

	Basic Services, including Diagnostic, Preventative, Endodontics, Periodontics & Surgery	Major Restorative	Orthodontics
Agriculture, Forestry & Fisheries	100%	29%	5%
Construction	100%	34%	7%
Finance, Insurance & Real Estate	100%	44%	10%
Manufacturing	100%	36%	10%
Mining	100%	73%	24%
Public Administration	100%	70%	43%
Retail Trade	100%	31%	7%
Services	100%	39%	9%
Transportation, Communications & Utilities	100%	43%	11%
Wholesale	100%	37%	9%
Total	**100%**	**38%**	**9%**

Employer industry – Standard Industrial Classification System (SIC)

Co-insurance

Co-insurance for dental plans is very common in plans across all employer sizes. Co-insurance often varies by type of dental service. Virtually all plans offering major restorative and orthodontic coverage have co-insurance.

% of plans with co-insurance

Size of employer (# of employees)	Diagnostic, Preventative	Periodontic, Endodontics	Surgical	Major Restorative	Orthodontics
Less than 10	75%	75%	75%	100%	99%
10 to 19	75%	76%	76%	100%	100%
20 to 49	74%	75%	74%	100%	100%
Total	**75%**	**75%**	**75%**	**100%**	**100%**

% of plans with co-insurance

	Diagnostic, Preventative	Periodontics, Endodontics	Surgical	Major Restorative	Orthodontics
Agriculture, Forestry & Fisheries	78%	78%	65%	100%	79%
Construction	78%	78%	73%	100%	78%
Finance, Insurance & Real Estate	67%	67%	71%	100%	67%
Manufacturing	78%	78%	70%	99%	78%
Mining	54%	54%	43%	99%	55%
Public Administration	43%	44%	31%	99%	44%
Retail Trade	81%	81%	86%	100%	82%
Services	74%	74%	61%	100%	74%
Transportation, Communications & Utilities	77%	78%	61%	100%	78%
Wholesale	75%	75%	71%	100%	75%
Total	**75%**	**75%**	**64%**	**100%**	**75%**

Not only does the instance of co-insurance vary by type of dental service, so do co-insurance levels. Diagnostic, preventitive, periodontics, endodontics and surgical are more likely to have co-insurance levels of 80% or greater, while major restorative and orthodontics are likely to have much lower levels. This is true across all employer sizes and industry groups.

Frequency of co-insurance levels

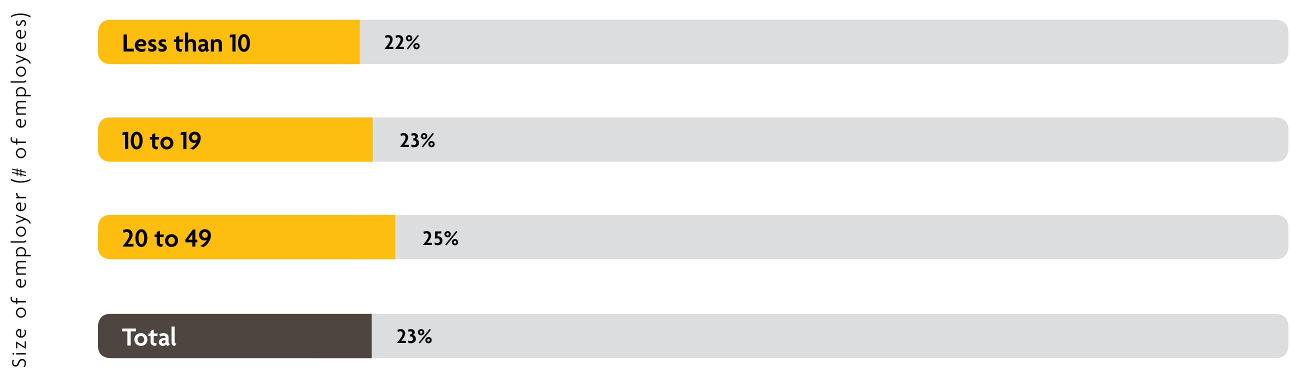
	50%	55%	60%	70%	75%	80%	85%	90%
Diagnostic, Preventative	1%	0%	0%	4%	1%	89%	0%	5%
Periodontics, Endodontics	1%	0%	0%	4%	1%	89%	0%	5%
Surgical	2%	0%	0%	4%	2%	74%	1%	15%
Major Restorative	87%	0%	2%	1%	0%	9%	0%	0%
Orthodontics	96%	0%	4%	0%	0%	0%	0%	0%

Deductibles

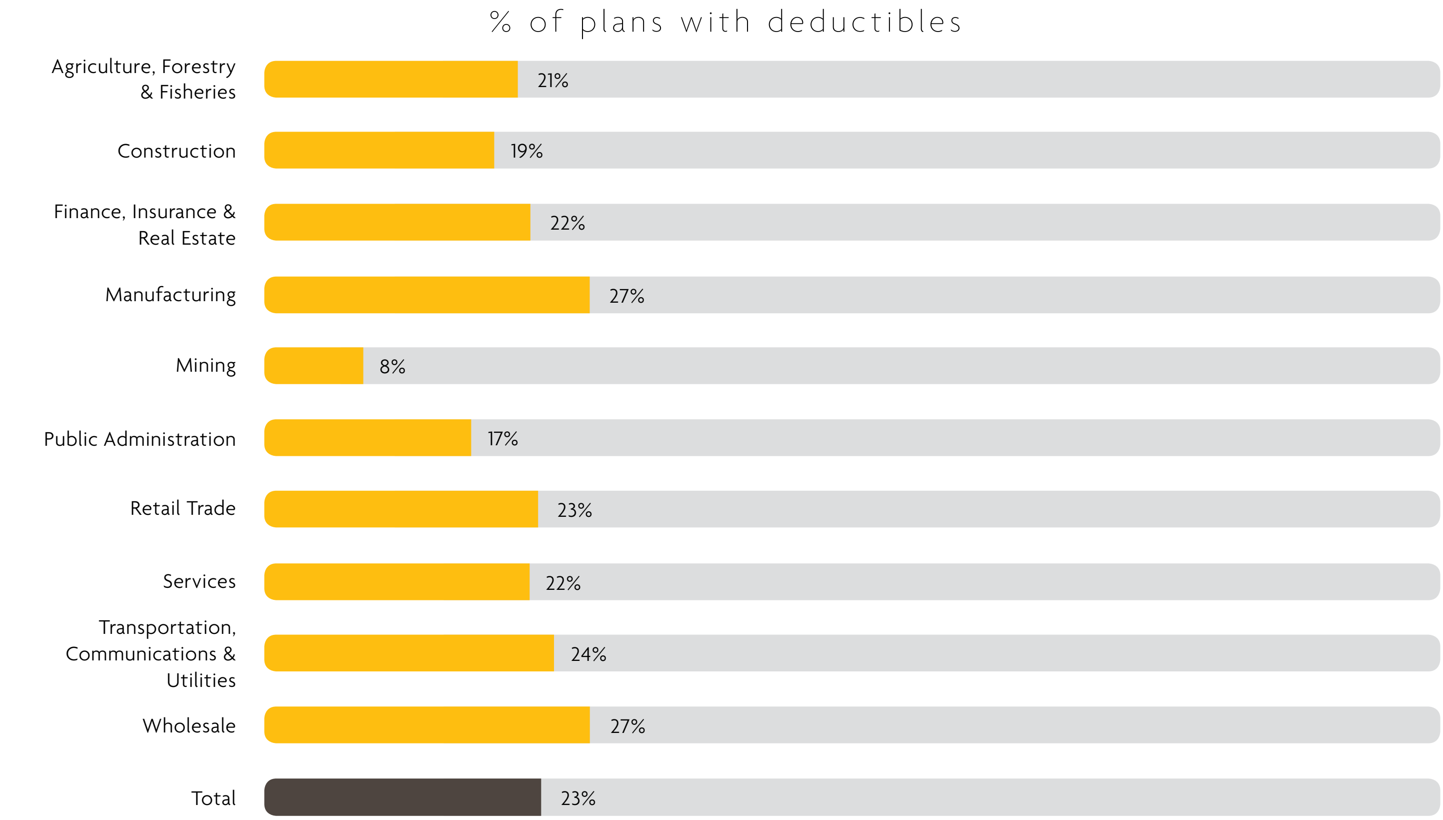
The majority of dental plans (77%) do not have deductibles, with most plans choosing co-insurance as a primary cost control measure.

While deductibles for dental work can discourage what may be non-essential, smaller value claims, co-insurance is often a more effective plan design tool to share costs and promote more judicious use of benefits, making it a good fit for high cost expenses like dental work that may not always be immediately critical to employee health and productivity.

% of plans with deductibles



There is some variability in the use of deductibles when looked at across industries, with the plans of wholesale and manufacturing employers most likely to have them (27%) and mining the least likely (8%).



Employer industry – Standard Industrial Classification System (SIC)

Plans with deductibles for dental expenses include both deductible amounts for individuals as well as families, in the case of employees who have dependents covered under their plan. The most common individual deductible amount is $25 and $50 for individual and family deductibles respectively. This is true across employer sizes and industries.

LEADING THE DIGITAL FUTURE

There is no question that a great digital group benefits experience is key to employee satisfaction and engagement.

Not surprisingly, the trend is moving toward increased mobile app usage. Forty-five percent of all Sun Life group benefits plan members are active Sun Life app users and that number is growing fast. As of April 2018, compared to April 2017, we saw a 6% decrease in web only users. However, during the same time period, the number of mobile-only users grew by 78%.

Far more than submitting claims...

Group benefits mobile apps are evolving with convenient and empowering features beyond claims submission. For example, leading mobile apps allow members to:

- Get their claim paid within 24 to 48 hours, thanks to instant adjudication
- Look up drug information, and be alerted to generic or therapeutic alternatives that could save them money
- Find a health care provider near them as well as view provider ratings submitted by other employees
- Seamlessly interact with both their health and retirement benefits plans when both plans are with the same carrier

Sun Life aspires to be the best digital group benefits provider in Canada and is leading the charge... just look at our latest mobile app statistics:

4.6 stars on iTunes, higher ratings than Uber and Facebook![5]

400,000 app downloads last year, up **69%** over 2016

5 million mobile app group benefits sessions last year, up **75%** over 2016

1.7 million health claims submitted last year, up **58%** over 2016

4 million health provider ratings and counting, spanning over 100,000 providers[6]

[5] As of July 31, 2018
[6] As of July 31, 2018

The future is here...meet Ella, your personal digital benefits coach!

Launched by Sun Life in 2017, Ella, is the industry's first intelligent digital coach. Ella is designed to help Canadians by providing relevant and personalized Group Benefits and Group Retirement Services related advice.

Powerful data analytics, combined with Sun Life's wealth of Client data allows Ella to anticipate Client needs and offer tailor-made advice. Over time, Ella will learn from our Clients with each interaction to provide increasingly proactive and personalized suggestions and help.

Ella has been introduced on the mysunlife.ca secure employee site and the employee mobile app.

Here are two examples of how Ella can help:

- If a member didn't know that their employer will match their retirement savings – Ella can help ensure the member takes advantage of those benefits
- If a member's dependant is turning 21, and they didn't realize they will soon need their own health care coverage to replace their benefits coverage – Ella can alert the member to this and possible solutions

UTILIZATION

The following benefits plan utilization data is taken from our database of employee claiming information for employers having under 50 employees.[7]

Looking to the future, benefit plan utilization data will become increasingly important. Utilization patterns will be affected by several trends. An aging workforce is one such notable trend. By 2021, 25% of the workforce will be age 55 years or older, the highest proportion ever.[8] The rising incidence of chronic disease is another. For example, by 2020, 4.2 million Canadians will be diabetic, up from 2.7 million in 2010.[9]

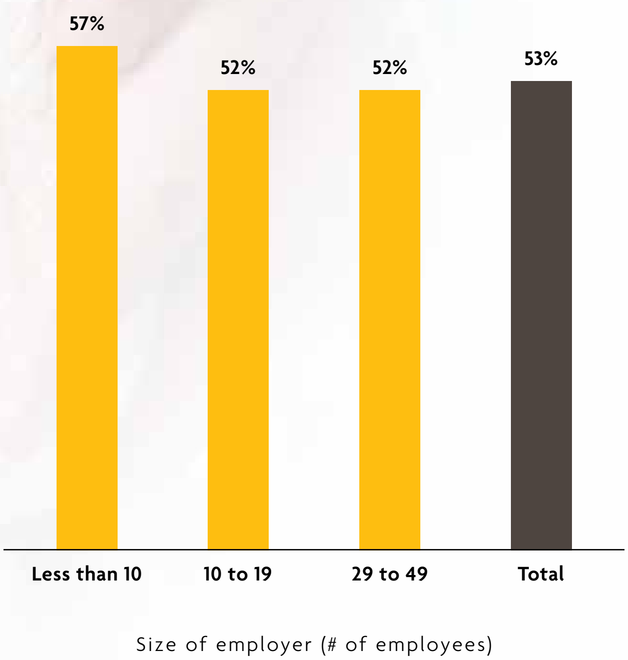
This means more than ever, it pays to know your workforce and the factors that may be influencing how your plan is being used. Attention to plan design is critical, as plan design features can help ensure employers and employees get the most value from their benefit dollars, while protecting the sustainable of their plans into the future.

[7] Data is from January 31st 2016 and is exclusive of employee data from the Public Service Health Care Plan
[8] Statistics Canada: Projected trends to 2031 for the Canadian Labour Force
[9] Canadian Diabetes Association, Diabetes in Canada, May 2015

Paramedical

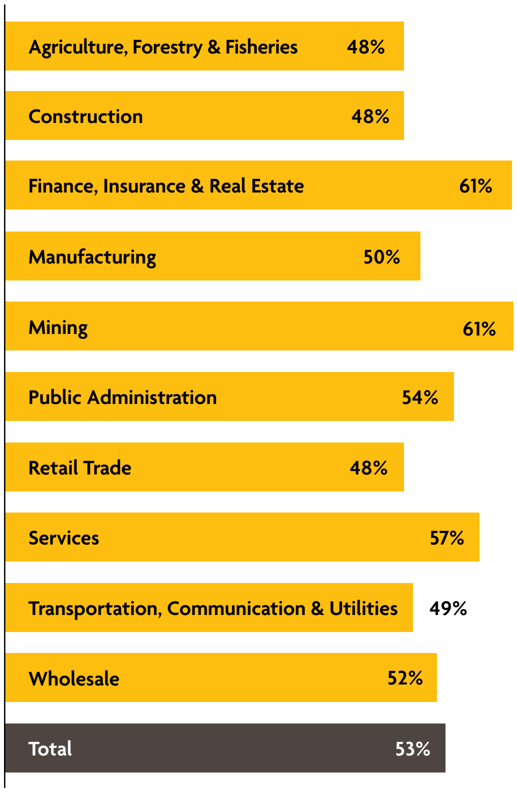
Just over half of employees made a claim for at least one paramedical service during the calendar year, with a slightly higher incidence seen among smaller employers.

% of employees who made at least one paramedical claim



There is relative consistency across industries, with employers in mining, finance, insurance and real estate having somewhat of a higher incidence of claiming employees.

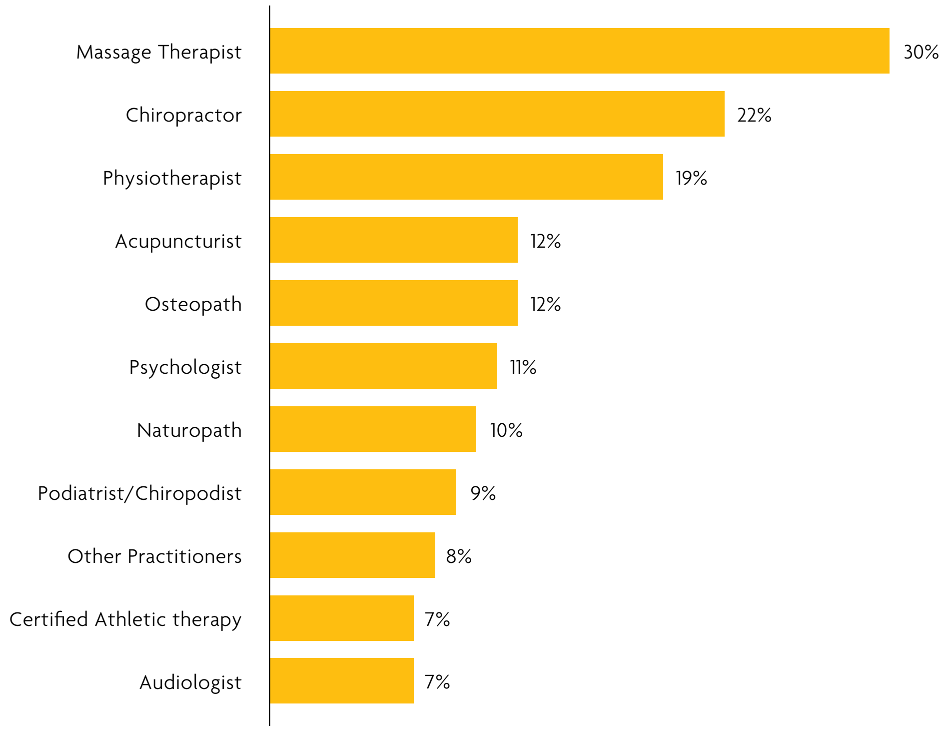
% of employees who made at least one paramedical claim



Employer industry – Standard Industrial Classification System (SIC)

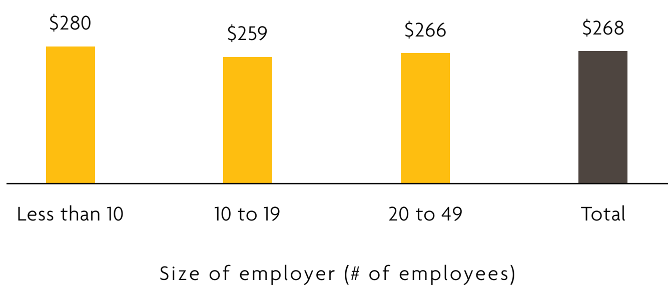
Massage therapy is the most common service being claimed, followed by claims for chiropractic services.

% of employees who made at least one claim*



When we look at cost, we see that the highest average cost per covered member occurs in plans of the smallest employer size, the group that has the highest percentage of claiming members.

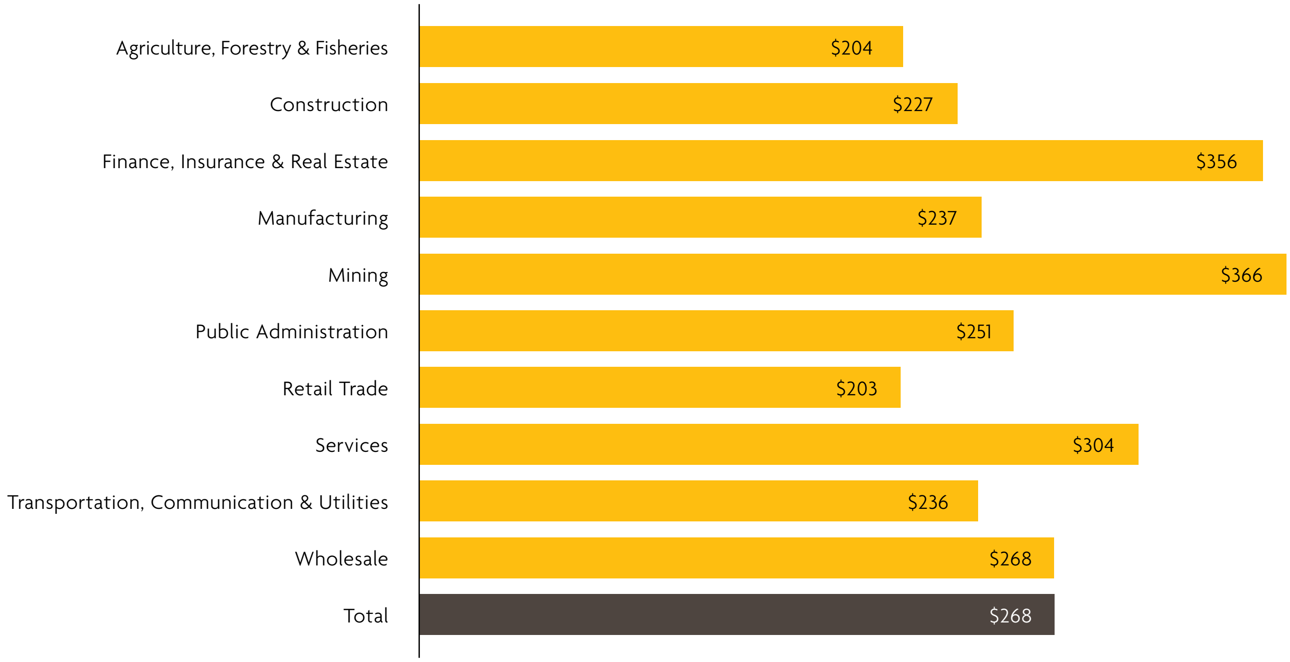
Average annual total cost of claims per covered member



*based on employees who made at least one paramedical claim during the calendar year

The differences in cost seen across industries can be attributed in part to plan design. Industries whose plans are least likely to have co-insurance and deductibles have higher utilization. The opposite tends to be true for industries whose plans are more likely to include co-insurance and deductibles. Mining is an example of the former, while retail trade exemplifies the latter.

Average annual total cost of claims per covered member

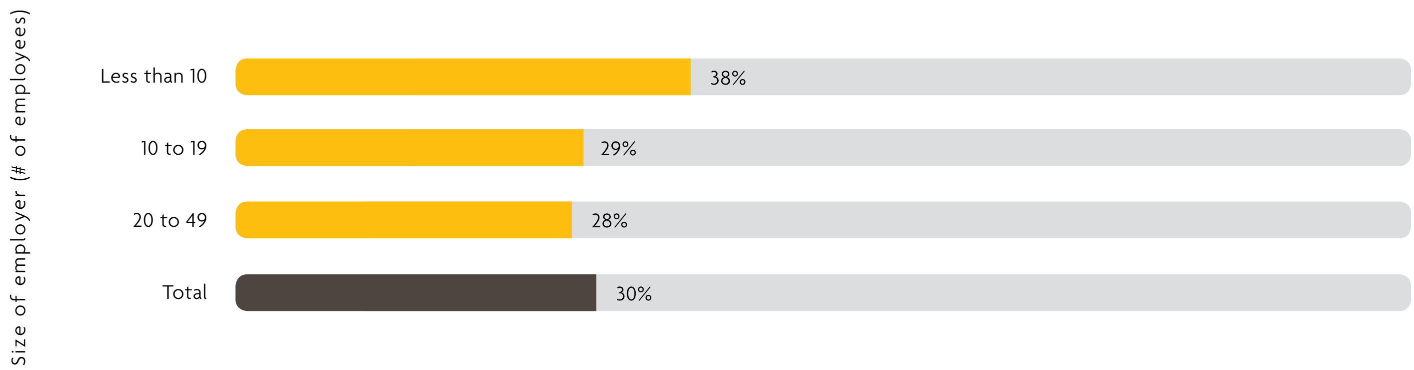


Employer industry – Standard Industrial Classification System (SIC)

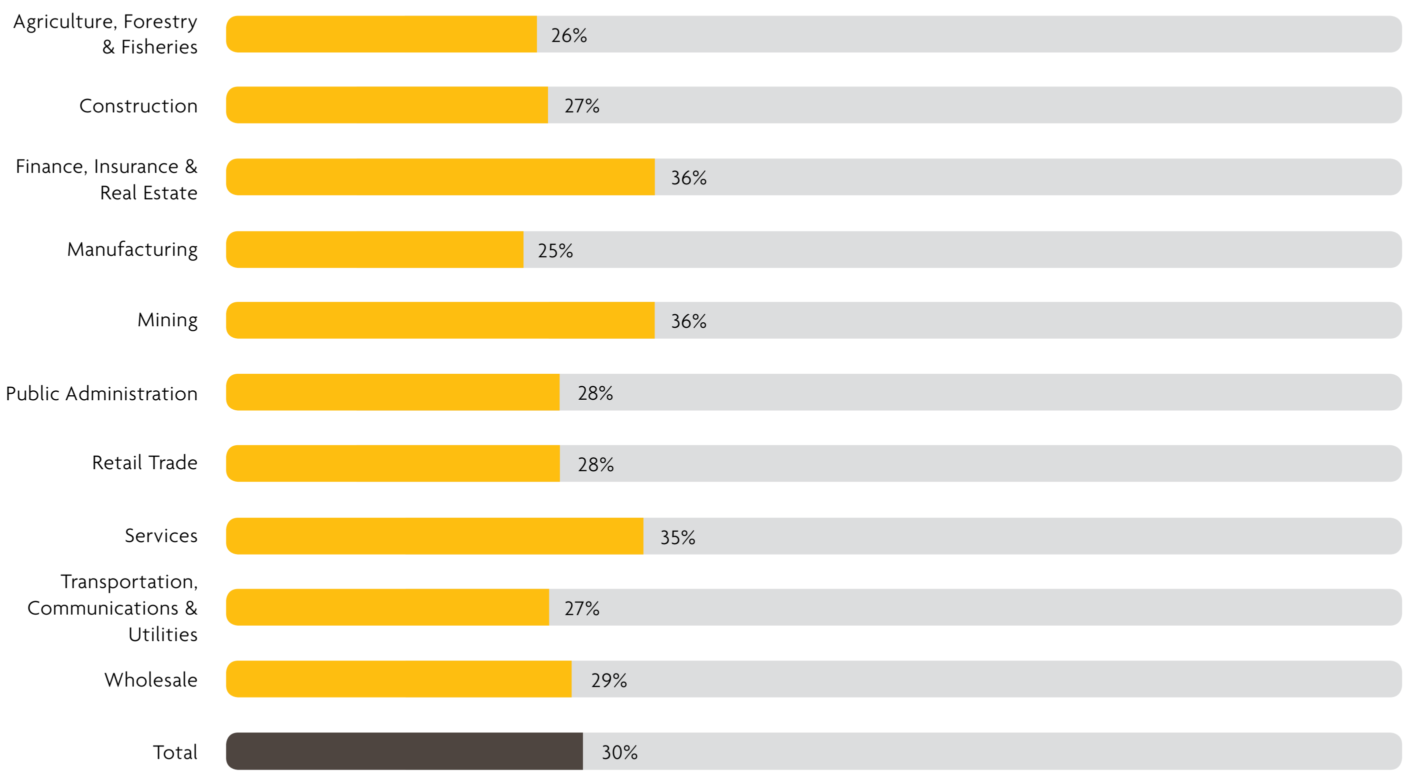
A closer look at massage therapy claims

Massage therapy is the most common paramedical service claimed. Consistent with overall utilization of paramedical providers, employees of smaller employers as well as those in the services, mining and finance, insurance & real estate sectors stand out as the most frequent users of massage therapy.

% of employees who made at least one massage therapy claim*



% of employees who made at least one massage therapy claim*

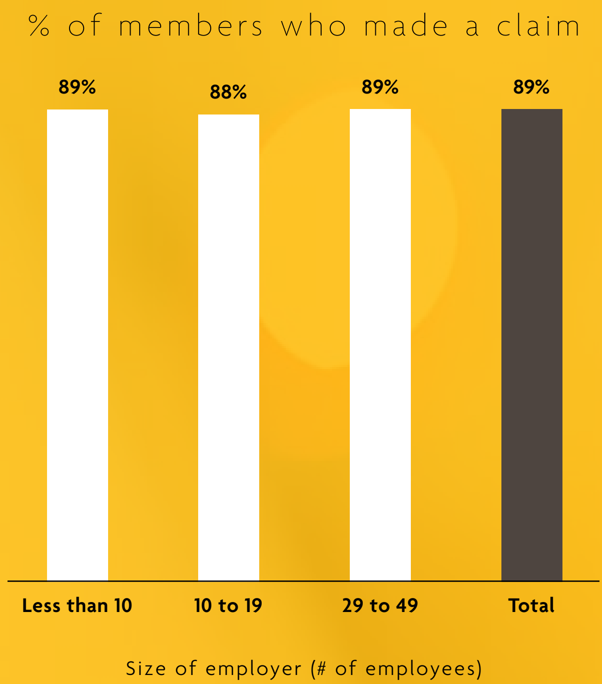


Employer industry – Standard Industrial Classification System (SIC)

*based on employees who made at least one paramedical claim during the calendar year

Prescription drugs

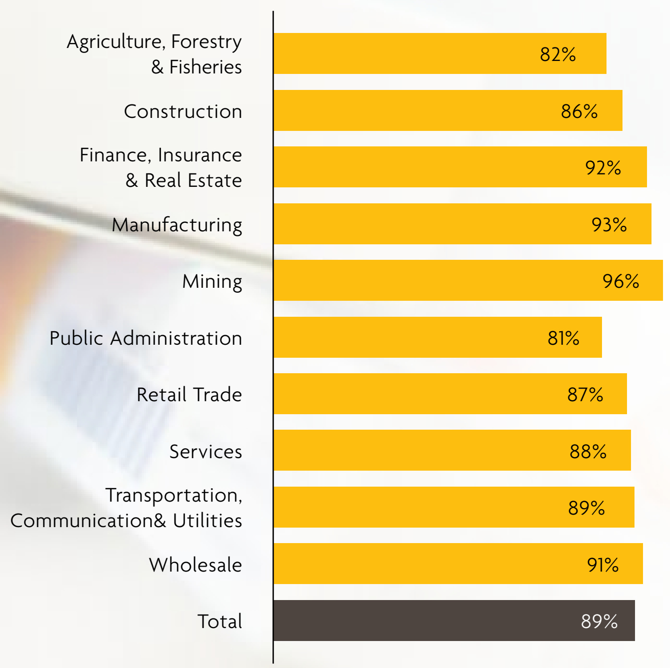
Overall, 89 percent employees made at least one drug claim in the calendar year. Incidence of claiming is consistent across employer size.



The public administration sector has a lower incidence of claiming employees, with this sector standing out with the highest incidents of co-insurance likely a factor.

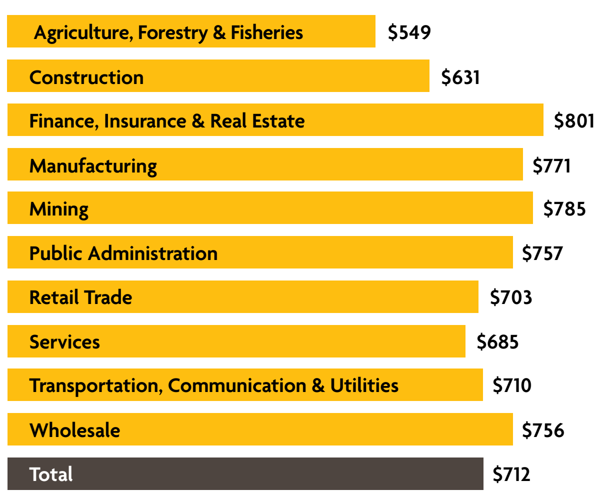
From a cost perspective, plans of the smallest employer group have a somewhat higher total cost of claims per covered employee. By industry, the differences in cost track utilization patterns relatively closely.

% of employees who made a drug claim



Employer industry – Standard Industrial Classification System (SIC)

Average annual total cost of claims per covered member

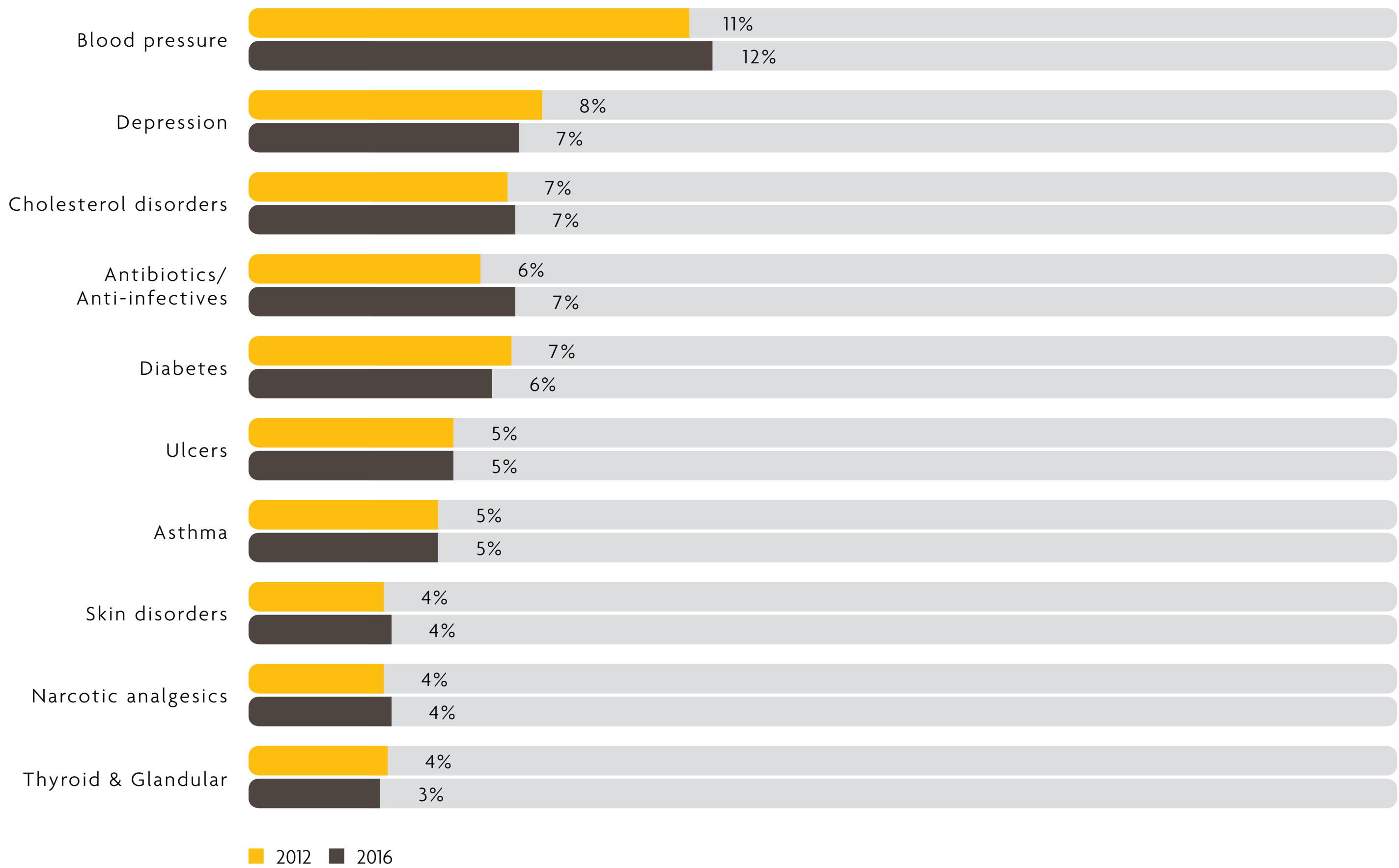


Size of employer (# of employees)

A look at drug claiming trends by disease category[10]

Over a five year period starting in 2012, there was little change in the top 10 disease categories based on the **percentage of total claims** each category accounted for. While there were small changes in claiming percentages for some conditions, the order of the top 10 list of disease categories by claim volume from 2012 to 2016 for the most part remained the same.

Top 10 disease categories (% of drug claims)



[10] Based on Sun Life's **total block of business** (across employer sizes and industries) for the calendar year 2016, exclusive of the Public Service Health Care Plan

The new era of high-cost specialty drugs

The emergence of high-cost specialty drugs is a key driver of drug cost growth which is forecast to increase in the coming years. Developed to treat life-threatening and complex chronic conditions, these drugs can be highly effective, but come at very high costs, often in the tens of thousands per claimant per year.

Between 2013 and 2016, the percentage of total drug spend represented by specialty drugs increased from 18% to 28% across Sun Life's block of business. Given that many more specialty drugs are set to enter the market to treat a variety of conditions, it is forecast that drug plans will increasingly come under cost pressure.

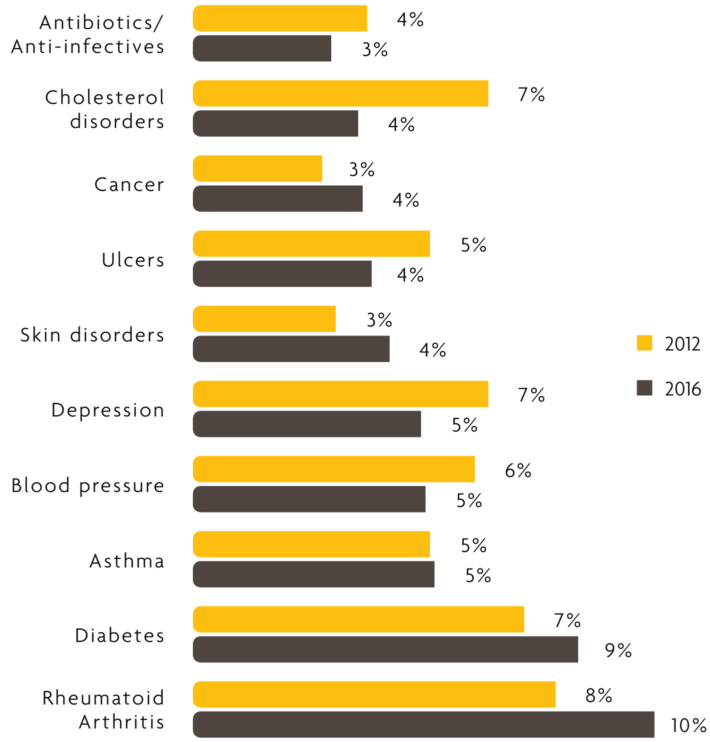
Drug plan design features such as prior authorization and managed formularies will be essential to protect drug plan sustainability in this new era of high cost drugs.

Looking at the top 10 disease categories ordered by the **percentage of total claim costs** each category accounts for, yields some interesting insights, especially when looked at over a five year period.

Several disease categories experienced significant increases or decreases in the proportion of claim payments they represent over a five-year period. Payments for arthritis, diabetes, skin disorders and cancer increased. These are diseases for which new drugs have entered the market and for which there are no generic alternatives – several of these are high cost, specialty medications.

Meanwhile, the five year period starting at 2012 saw payment amounts for cholesterol disorders, ulcers, blood pressure, depression and antibiotics decreased. Many therapies for these conditions were brand name drugs that have come off patent in recent years. With the availability of generic alternatives for these drugs now available, the cost of drug therapies to treat these disease categories has declined.

Top ten disease categories (by total $ amount of claims)



Specialty drug spending

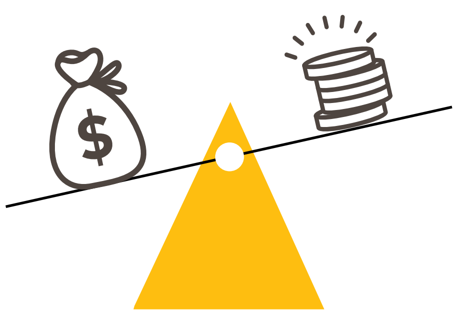
■ / Cost per claim ■ / Cost per claimant per year

Specialty

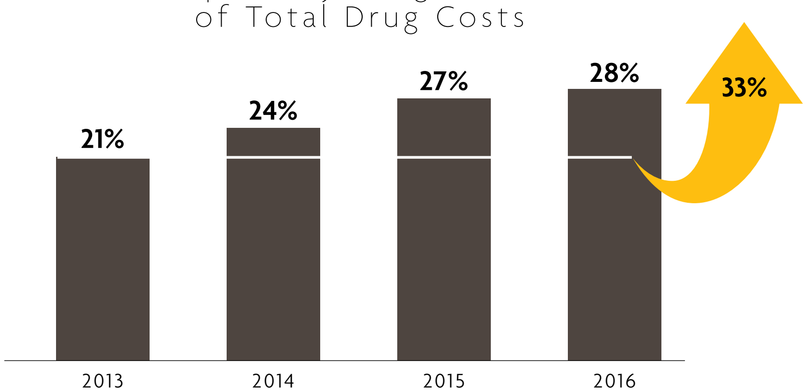
$1,435 | **$6,597**

Traditional

$33 | **$89**



Specialty Drug Share of Total Drug Costs

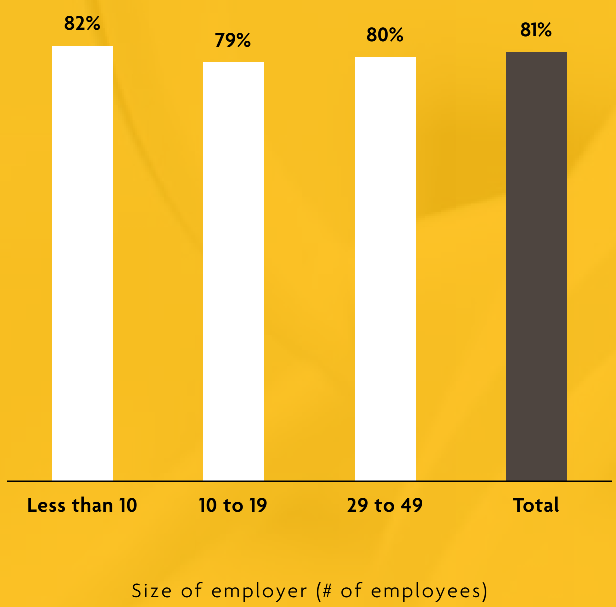


Based on Sun Life Block of Business for the 2016 calendar year, exclusive of the Public Service Health Care Plan

Dental

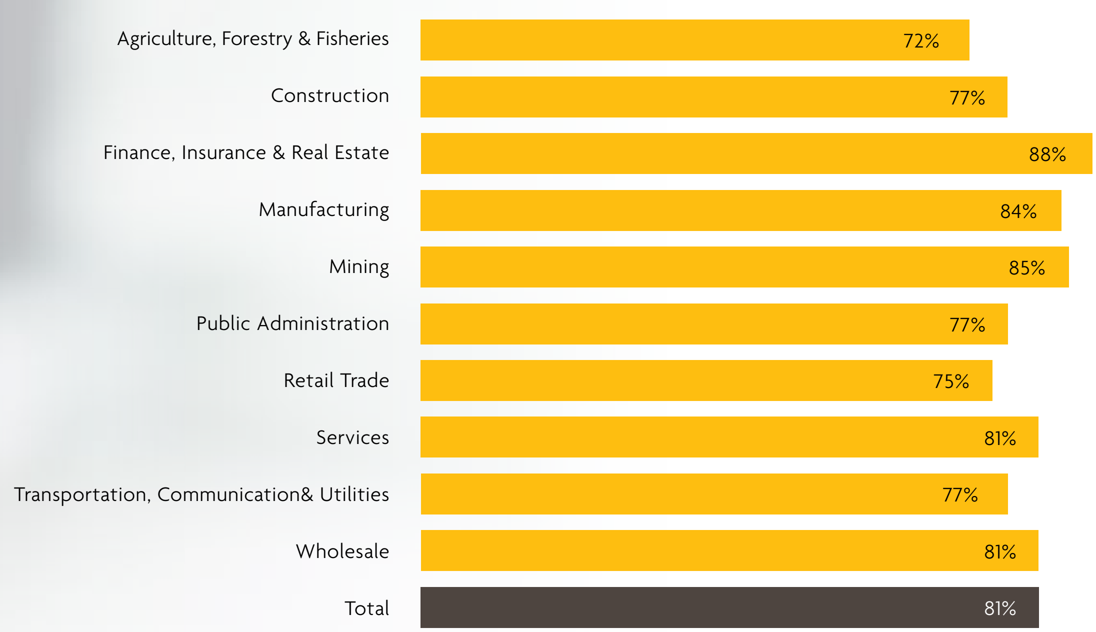
Dental plan utilization is high, with 81% of all employees making at least one claim during the calendar year. Incidence of claiming is consistent across employer size.

% of members that made at least one claim



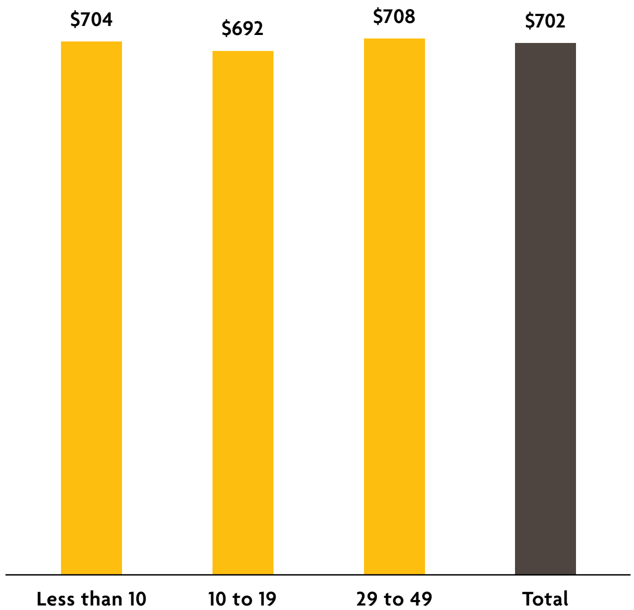
There is some variation in utilization seen across industries. Plan design is likely again playing a role, with higher utilization industries such as mining, finance, insurance also having lower incidences of co-insurance, for example.

% of employees that made at least one claim



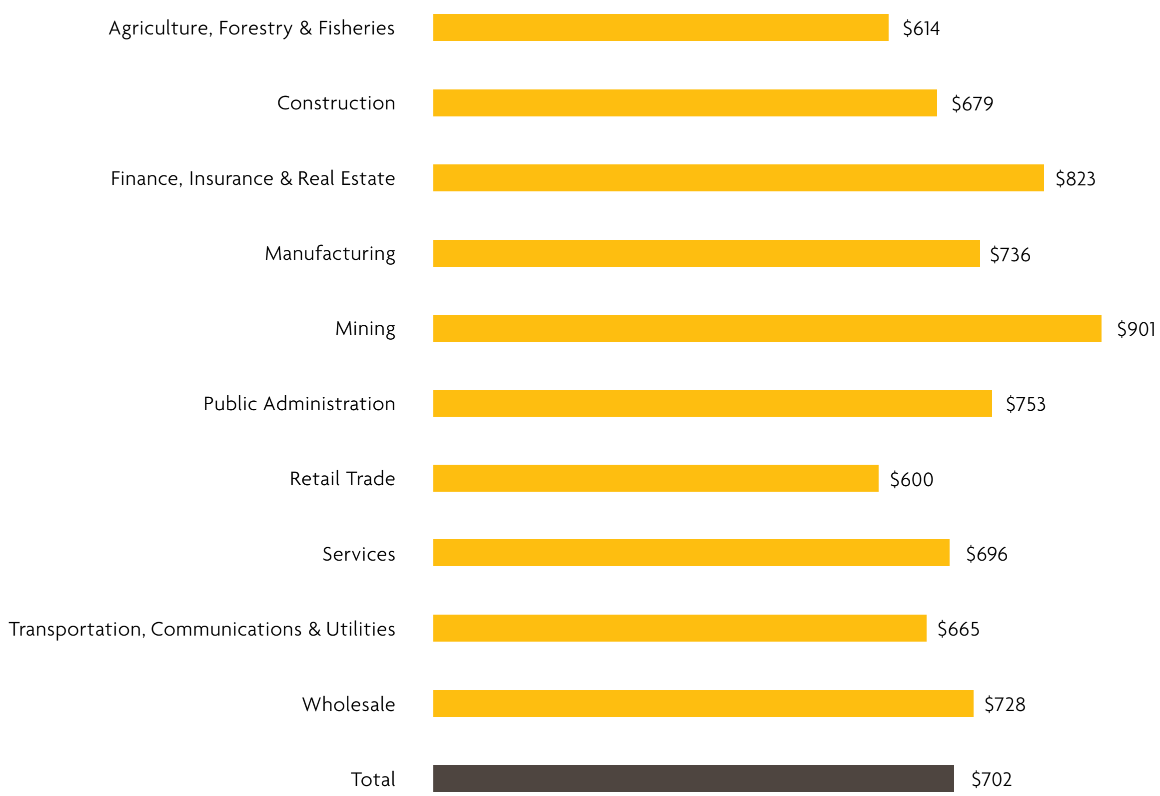
Total cost of claims per covered members is consistent across plan sizes. There is some variation by industry. As to be expected, sectors with higher utilization generally have higher costs per covered employee (as mentioned previously, these plans also tend to have lower levels of co-insurance).

Average annual total cost of claims per covered employees



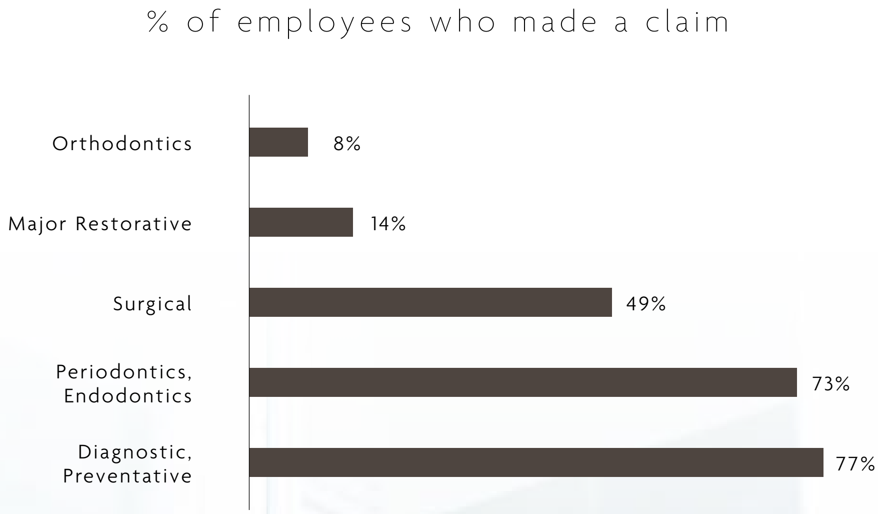
Size of employer (# of employees)

Average annual total cost of claims per covered employees



Employer industry – Standard Industrial Classification System (SIC)

Overall, for employees who made a claim, the vast majority were for diagnostic/preventive work or periodontic and endodontic treatment, with fewer claims for more extensive procedures.



DESIGNING A PLAN FOR THE HEALTH OF YOUR EMPLOYEES

In this report, we've provided you with insights from Canada's largest database of group benefits plan information, with a detailed snapshot of how employers across Canada have designed their plans – and how employees are using their benefits.

It's great information – but we should all be mindful of the limitations of benchmark data. The best group benefits plan, one that fits like a glove in terms of meeting the needs of your Clients and their employees is rarely designed by averages. Your role is critical in helping Clients identify their overall objectives and needs, then working with them to design a plan that meets these needs and fits within any financial or other constraints.

We hope the information in this report helps you serve your Clients – and enhances your business success.

About the data in this report

The data in this report is drawn from Sun Life's block of business, excluding the Public Service Health Care Plan.

Plan design data is reported at the employer level. In the case of employers with multiple plans, data from the plan with the largest number of employees is reported. Unless otherwise stated, data is as of December 31, 2016.

Employee utilization data reflects the entire employee population (excluding the Public Service Health Care Plan), and unless otherwise stated, represents the 2016 calendar year.

Sun Life Financial