Employee Group Benefits Booklet

Northstar Demo Benefits Company

Maple Arc Systems Incorporated

Comprehensive Employee and Family Plan

SAMPLE ONLY - NO INSURANCE COVERAGE IS PROVIDED

This fictional booklet describes an employer-sponsored benefits plan for employees and their eligible family members. It contains prescription drug, health, dental, vision, disability, life and travel benefits with separate limits and conditions. It is designed for demonstrations and document question answering, not for use as a real insurance contract or medical, tax or legal advice.

Plan detail	Fictional plan information
Group policy	NDB-GB-482071
Division and class	Division 01 / Class A salaried employees
Employer	Maple Arc Systems Incorporated
Administrator	Northstar Demo Benefits Company
Effective date	January 1, 2027
Booklet edition	2027.01, including amendments A01 and A02
Benefit year	January 1 through December 31
Currency	Canadian dollars throughout

Read the applicable benefit section before relying on a summary. Eligibility, exclusions, claim deadlines and amendments apply together. Dollar maximums are amounts payable by the plan, not amounts billed by a provider, unless a rule explicitly says otherwise.

All organizations, plan identifiers, benefits and examples are invented. No actual employer or insurer has issued this booklet. The fictional contact address is benefits@northstar-demo.example. It is not monitored; do not send personal information or claims to it.

The booklet uses stable section identifiers so answers can cite a clause even when an editable Word copy is repaginated. For example, V01 identifies vision coverage and D03 identifies orthodontics. All examples assume eligibility and sufficient unused limits unless stated otherwise.

Guide to the booklet

Finding an answer

Use the section identifier below to locate the relevant wording. Read both the base benefit and the amendments. A01 changes massage coverage from July 1, 2027. A02 adds a limited accidental dental exception. Neither amendment changes unrelated benefits.

Section	Subject
G01	Eligibility and enrolment
G02	Dependants and family changes
G03	Payment rules and annual limits
RX01	Prescription drugs
RX02	Special medications and authorization
H01	Hospital and medical services
V01	Vision care
P01	Physical and complementary therapies
P02	Mental health and counselling
H02	Medical equipment and supplies
D01	Preventive and basic dental
D02	Major dental services
D03	Orthodontics
T01	Emergency travel medical
T02	Travel assistance and exclusions
L01	Life and accidental loss benefits
DI01	Short term disability
DI02	Long term disability
A03	Spending accounts and assistance
C01	Claims and reimbursement
C02	Coordination with other plans
G04	Leave and end of coverage
G05	Exclusions and interpretation
A01 and A02	Changes to the base benefits
X01	Worked benefit examples
X02	Definitions and quick reference

G01 Eligibility and enrolment

G01.1 Eligible employees

You qualify for Class A when you are a permanent employee of the fictional employer, normally work at least 24 hours each week, reside in Canada and complete 90 consecutive calendar days of employment. Coverage starts on day 91 if you are actively at work. A hire date of January 1, 2027 produces an eligibility date of April 1, 2027. Approved paid vacation counts as active work if you were capable of performing your regular duties immediately before the vacation.

Employees hired on a casual, seasonal or independent-contractor basis are not eligible under this class. A transfer from another class does not automatically import that class's limits. The benefits administrator must confirm the new effective date and record the applicable class.

G01.2 How to enrol

Submit your employee details, dependant information and beneficiary designation within 31 days of becoming eligible. Extended health and travel require provincial or territorial health coverage for each insured person. Dental and life benefits do not require provincial health coverage. Employee disability and basic life coverage cannot be waived.

You may waive extended health and dental if you have comparable coverage through another group plan. If that coverage ends, request enrolment within 31 days of the loss and supply the other plan's termination confirmation. Coverage then begins the day after the other plan ends, provided you otherwise qualify.

G01.3 Late applications

A late applicant must provide evidence of insurability for life benefits. Extended health starts on the approval date, without payment for earlier expenses. Late-applicant dental is limited to $250 payable per person during the first 12 months of that person's dental coverage, including basic and major services; orthodontics is excluded during that period. The normal annual limits also apply and do not override the temporary restriction.

Event	Requirement
Employee application	Within 31 days of eligibility
Loss of alternate coverage	Apply within 31 days
Not actively at work on start date	Start deferred until return to active work
Part time hours fall below 24	Notify administrator within 14 days

An enrolment confirmation is not an authorization for a particular treatment. Check the relevant clinical and expense requirements separately.

G02 Dependants and family changes

G02.1 Spouse eligibility

One spouse may be covered: either your legally married spouse or your partner with whom you have lived continuously in a conjugal relationship for at least 12 months. A spouse must live in Canada. A separation does not automatically update the enrolment record; report the change and obtain written confirmation of the effective date. You cannot cover both a former spouse and a new partner under this specimen plan.

G02.2 Dependent children

An unmarried child qualifies until the end of the month of their 21st birthday if financially dependent on you or your spouse. Full-time students at an accredited school qualify until the end of the month of their 25th birthday. Stepchildren and legally adopted children are included on the same basis. Student status must be renewed each September with a dated school confirmation.

A child who becomes incapable of self-support because of a disability before the ordinary age limit may continue if chiefly dependent on you. Apply within 31 days after the ordinary limit would have ended coverage and provide supporting information. Ongoing proof may be requested no more than annually after the first two years. This continuation does not extend orthodontic eligibility beyond its separate age rule.

G02.3 Adding family members

Request a newborn's enrolment within 31 days of birth for coverage from birth. An adopted child's coverage can start on legal placement if requested within 31 days. The enrolment waiting period is not repeated for these dependants once the employee is covered. A new spouse's start date is the date the spouse definition is met, if reported within 31 days.

Family event	Effective date if timely reported
Birth	Date of birth
Adoption	Legal placement date
Marriage	Marriage date
Common law partnership	Date 12 months of cohabitation is completed
Student ceases full-time study	End of month student status ends

Family membership does not create a shared health maximum. Most health, dental and vision limits are separate for each covered person. The health spending account in A03 is the principal family-shared exception.

G03 Understanding payment and limits

G03.1 General calculation

For each claim, establish the eligible expense after provider fee limits and exclusions. Subtract any applicable remaining deductible, multiply by the reimbursement percentage, and cap the result at the remaining benefit maximum. Amounts paid by another plan cannot cause the combined reimbursement to exceed the eligible expense. Prior payments consume a maximum when they are allocated to the date of service, not the date a reimbursement reaches your bank.

Extended health has a $25 annual deductible per person, capped at $50 for the entire family. It applies only to H01 medical services and H02 equipment and supplies. It does not apply to prescription drugs, vision, therapies, mental health, dental, travel, spending accounts or insured lump-sum benefits. Prescription drugs instead have a separate per-fill deductible.

G03.2 Meaning of a maximum

Unless expressly described as an eligible-expense cap, a dollar maximum limits the plan's payment. An 80% benefit with a $500 payable maximum can reimburse up to $500, not merely 80% of $500. No unused annual maximum carries forward, except the spending-account carryforward in A03. Lifetime maximums do not reset at renewal or after a temporary absence.

Limit basis	How it resets
Calendar year	January 1 of each year
Rolling 24 months	Measured from the relevant service date
Per trip	At the start of a new eligible trip
Lifetime	Does not renew
Combined maximum	One pool shared by listed services

G03.3 Expense timing and provider charges

A service is incurred when performed; glasses when dispensed; drugs when dispensed; and rental equipment for each rental period. A quotation, deposit or prepaid package is not an incurred service. Fees above the explicit caps in this booklet are not eligible. Where no explicit cap exists, the billed charge is eligible if the service otherwise qualifies under this fictional plan.

An amendment that takes effect midyear uses the service date. It does not restart a calendar-year maximum or restore payments already used. All limits are per person unless identified as family, employee or policy limits.

RX01 Prescription drug coverage

RX01.1 Payment schedule

Eligible prescription drugs are reimbursed at 80% after a $5 deductible for each prescription fill. The annual maximum is $10,000 payable per covered person. A dispensing fee of up to $8 per fill is included in the eligible amount before the $5 deduction. The $25 health deductible does not apply. Approved claims under RX02 also use the $10,000 pool unless explicitly described otherwise.

Expense	Treatment under this plan
Lowest-cost interchangeable generic	Eligible drug ingredient cost
Brand when a generic is available	Limited to generic cost unless approved
Dispensing fee	Eligible up to $8 per fill
Maintenance supply	Up to 90 days per fill
First prescription for a new therapy	Up to 30 days before review
Nonprescription vitamins	Excluded

RX01.2 Eligible purchases

Drugs must have a Canadian drug identification number, require a prescription under this plan and be dispensed by a licensed pharmacy. Insulin, prescribed injectable allergy preparations and prescribed diabetic testing supplies are exceptions to the prescription-only retail classification. Testing supplies have a $1,000 annual payable sublimit within the drug maximum. Continuous glucose monitors are considered under H02 instead.

Refills are eligible when at least 75% of the previous supply would normally have been used. A travel supply of up to 180 days requires approval before dispensing, remains subject to the annual maximum and does not extend emergency travel coverage.

RX01.3 Generic substitution and exclusions

If a $90 brand ingredient has a $40 interchangeable generic, only $40 is eligible unless the administrator approves documented intolerance or treatment failure. A prescriber's brand-only notation by itself is insufficient. Cosmetic drugs, hair-growth products, over-the-counter remedies and medication supplied without a pharmacy receipt are excluded.

Example: an eligible generic ingredient costs $100 and the pharmacy charges a $12 fee. Eligible cost is $108. Subtract $5 and apply 80%: the plan pays $82.40. The member pays $29.60 of the $112 bill. The fee excess and member share may be submitted to the health spending account only if they meet A03 eligibility.

RX02 Special medications and authorization

RX02.1 Prior authorization

Specialty biologics, fertility medications, anti-obesity medications and smoking-cessation drugs require approval before the first reimbursable fill. Approval may depend on diagnosis, previous therapies and an anticipated treatment duration. Evidence is submitted by the treating prescriber; the employer receives only administrative status, not clinical records.

An approval states its start date, end date and any quantity limits. Approval confirms the drug's eligibility, not unlimited payment. The RX01 reimbursement formula, generic rules and remaining annual drug maximum still apply. Renewal requests should be submitted at least 30 days before approval expires.

Category	Payable sublimit	Additional condition
Fertility medication	$3,000 lifetime	Prescribed treatment plan
Anti-obesity medication	$1,500 per calendar year	Authorized supervised programme
Smoking cessation medication	$500 lifetime	One approved course per year
Adult preventive vaccines	$300 per calendar year	Not publicly funded for the member
Specialty biologics	Within $10,000 annual drug pool	Biosimilar first unless approved exception

RX02.2 Fertility services distinction

The fertility sublimit covers eligible medication only. Consultations covered by a provincial programme are not reimbursed again. Egg retrieval, embryo storage, donor fees and laboratory procedures are not insured under RX01 or RX02. Some otherwise eligible uninsured expenses may qualify under A03, but that is a separate balance rather than an expansion of the fertility drug benefit.

RX02.3 Review and appeals

A declined authorization will identify the missing criterion or exclusion. You may ask for a review within 90 days and provide new clinical evidence. Review does not waive a claims deadline, and an emergency purchase before approval is not automatically covered. If retrospective approval is granted, its written effective date controls which fills qualify.

Medication bought outside Canada is excluded from routine drug coverage. Drugs needed for an eligible emergency abroad may be considered under T01; they must not also be claimed under the routine drug pool. No real clinical decisions should be based on these invented requirements.

H01 Hospital and medical services

H01.1 Covered services in Canada

This benefit supplements provincial coverage. It does not replace a provincial plan or reimburse amounts the provincial plan would have paid if you had enrolled. Eligible expenses are paid at 100% after the applicable G03 health deductible, subject to the limits below. Prior approval is required for private-duty nursing and an air ambulance that is not arranged under the travel benefit.

Service	Payable maximum and condition
Hospital room upgrade	Semi-private differential, up to $200 per day; 60 days per year
Ground ambulance	$500 per trip; $2,000 per year
Air ambulance in Canada	$5,000 per year; medical necessity and prior approval
Private-duty registered nursing	$10,000 per year; physician care plan
Uninsured diagnostic laboratory tests	$300 per year; physician order
Medically necessary travel within Canada	$1,000 per year; preapproved referral over 200 km

H01.2 Nursing and hospital restrictions

Nursing must be performed by a registered nurse who does not normally live with you and is not an immediate family member. The care plan must describe skilled nursing tasks and expected hours. Companionship, housekeeping, routine feeding and services already provided by a hospital are excluded. A personal support worker's invoice is not a registered-nursing claim.

For a private hospital room, only the eligible semi-private differential is considered. If the semi-private charge is $180 and a private room costs $300 above ward accommodation, the eligible expense is $180, not $300. Once the health deductible is satisfied, payment is $180 if days remain.

H01.3 Diagnostics and transport

Uninsured diagnostic tests require the physician's order, an itemized laboratory invoice and confirmation that the member is not eligible for public payment. Routine executive screening packages, employment examinations and tests ordered solely for curiosity are excluded. Private MRI and CT scans are not covered under this section.

Ambulance transportation must be medically necessary rather than a matter of convenience. Accessible taxis and mileage to ordinary appointments are excluded. Approved medical travel covers the patient's economy transport only; accommodation and a companion's travel are excluded. Emergency expenses outside the home province may instead qualify under T01, without duplicate payment.

V01 Vision care

V01.1 Adults and children

Vision is reimbursed at 100% with no deductible. Age is determined on the dispensing or examination date. The adult eyewear interval is rolling, not two calendar years. A change in prescription does not by itself reset the interval.

Expense	Member aged 18 or older	Member under 18
Prescription glasses and contacts	$300 combined in any rolling 24 months	$250 combined per calendar year
Eye examination	$90 in any rolling 24 months	$90 per calendar year
Laser vision correction	Uses adult $300 eyewear pool	Excluded
Nonprescription sunglasses	Excluded	Excluded

V01.2 Eligible eyewear

Frames, prescription lenses, necessary coatings, prescription sunglasses and prescription contact lenses share the eyewear maximum. Contact-lens fitting is included in that same pool. Repairs and replacement of lost glasses also use the pool; they do not create a separate allowance. A prescription and an itemized dispensing receipt are required.

Adults may claim several purchases during a rolling interval. On each new service date, payments for eyewear in the immediately preceding 24 months count against the $300 maximum. An earlier payment drops out on its 24-month anniversary. A $220 payment on March 10, 2027 therefore leaves $80 until March 10, 2029, assuming no other eyewear claims.

V01.3 Transition at age 18

For the first adult eyewear claim, eyewear payments received under the child benefit during the preceding 24 months count against the adult $300 allowance. This prevents an additional full allowance solely because the member turns 18. Eye examination payments use the same transition method against the separate $90 adult examination limit.

Examinations eligible for public payment are not reimbursed again. Surgery to treat disease is not laser vision correction under this benefit. Cosmetic lenses, cleaning fluids, ordinary reading glasses without a prescription and warranties are excluded.

Example: an adult purchases $520 prescription glasses with the full adult allowance available. The plan pays $300. An eligible $110 eye exam on the same day can receive another $90 if the examination allowance is unused. The combined payment is $390, not $300, because eyewear and exams have separate limits.

P01 Physical and complementary therapies

P01.1 Base schedule

Services are reimbursed at 80% with no deductible. Maximums below are payable amounts per person per calendar year. Practitioners must hold the applicable registration or licence in the province where they practise. A spa's business licence is not a professional credential.

Practitioner	Base annual maximum	Referral rule
Physiotherapist	$750	No physician referral
Registered massage therapist	$500 before A01 change	Physician referral dated before treatment
Chiropractor	$500	No referral; imaging uses this same pool
Osteopath and acupuncturist	$400 combined	No physician referral
Podiatrist and chiropodist	$400 combined	No physician referral
Speech-language pathologist	$1,000	No physician referral
Occupational therapist	$600	No physician referral
Registered dietitian	$300	No physician referral

P01.2 Important massage amendment

Amendment A01 increases the massage annual maximum to $750 for services from July 1, 2027 and removes the referral requirement from that date. Payments earlier in 2027 count against the new $750 total. The change is not an extra $750 allowance. The base rule above still governs services before July 1, even if submitted later.

P01.3 Eligible sessions and exclusions

Only completed individual assessment and treatment sessions qualify. Prepaid packages must be broken into individual dated services. Missed appointments, cancellation fees, tips, club memberships and products sold by the practitioner are excluded. Virtual sessions qualify only where the regulated professional can lawfully provide the relevant service remotely.

Massage must be therapeutic rather than a spa or relaxation package. Foot orthotics are not a practitioner session and must be claimed under H02. Psychological counselling does not use any P01 therapy maximum; it has its own combined pool in P02.

Example: a $120 physiotherapy visit produces a $96 payment. Eight such visits would ordinarily produce $768, but the annual maximum limits the total to $750. The eighth payment is $78 when the first seven have used $672.

P02 Mental health and counselling

P02.1 Combined mental health pool

Eligible counselling is reimbursed at 100% with a combined $2,000 payable maximum per person per calendar year. There is no deductible or physician referral requirement. The pool covers registered psychologists, registered psychotherapists and registered social workers providing mental health treatment. Their services are not separate $2,000 allowances.

Service	Covered treatment
Individual counselling	Eligible regulated provider
Virtual counselling	Provider authorized for the member's location
Couples or family counselling	Allocated to the identified patient, not every participant
Psychological assessment	Included within the $2,000 combined pool
Unregulated life coaching	Excluded
Missed appointment fee	Excluded

P02.2 Receipts and privacy

The receipt must name the patient, service date, provider, registration number, session type and amount. For family sessions, the provider identifies the person receiving treatment. One $200 family session cannot be claimed as $200 for each family member. An assessment report need not be sent with every routine receipt, but supporting clinical information may be requested confidentially when eligibility is uncertain.

Employer records show administrative enrolment and aggregate plan usage, not counselling notes. Do not submit session notes to a supervisor. In this fictional package, all email addresses ending in .example are non-operational placeholders.

P02.3 Distinction from assistance services

The employee assistance programme in A03 offers six short-term sessions per presenting issue per household. Those arranged sessions do not reduce this insured $2,000 pool. You cannot receive reimbursement for an assistance session already paid by the programme. A referral from the programme to ongoing private counselling starts using P02 if the provider qualifies.

Example: three psychologist sessions at $200 and four social-worker sessions at $150 use $1,200 of the combined pool, leaving $800. Adding a $1,100 eligible assessment produces an $800 payment, with $300 unpaid because the annual maximum is exhausted.

Inpatient addiction treatment, residential wellness retreats and tutoring are excluded from P02. Eligible prescribed medication is considered separately under RX01 and RX02. This booklet is coverage test data, not guidance about which treatment to seek.

H02 Equipment and medical supplies

H02.1 Payment rules

Eligible equipment and supplies are reimbursed at 80% after the remaining G03 health deductible. A prescription is required for every listed category. Prior approval is additionally required for any single purchase over $500 and for a rental expected to exceed three months. Payment cannot exceed the cost of a basic functional model when a premium model offers convenience rather than a necessary function.

Item	Payable maximum	Renewal or frequency
Custom foot orthotics	$400	Per calendar year; one pair
Hearing aids and repairs	$1,000 combined	Any rolling 60 months
CPAP machine	$1,500	Any rolling 60 months
CPAP masks and tubing	$250 combined	Calendar year
Wheelchair rental or purchase	$2,000 combined	Any rolling 60 months
Continuous glucose monitoring	$2,000	Calendar year; authorization required
Compression stockings	$200	Calendar year; two pairs
Breast prosthesis after surgery	$300	Calendar year
Wigs after covered medical treatment	$300	Any rolling 24 months

H02.2 Supporting records

Orthotics must be custom-made from an impression or three-dimensional scan. Include the prescription, assessment, fabrication details and paid invoice. Off-the-shelf insoles and shoes with an added generic insert are excluded. Hearing aids require an audiologist's assessment. CPAP requires a sleep-study recommendation and a supplier's equipment description.

The plan may approve rental instead of purchase for temporary conditions. Rental payments count toward the same item maximum and reduce a later purchase allowance. Replacement before the stated interval is excluded unless a documented material medical change makes the existing equipment unusable and the administrator approves an exception in writing.

H02.3 Excluded costs and example

Home renovation, exercise equipment, hot tubs, ordinary furniture, batteries for hearing aids and extended warranties are excluded. A doctor's note does not turn an excluded product into an insured item.

Example: a first claim for $400 eligible orthotics has a $25 health deductible remaining. The calculation is ($400 - $25) x 80% = $300. The $400 payable maximum is not reached; $100 remains in the monetary pool, but the one-pair frequency rule prevents a second pair that year.

D01 Preventive and basic dental

D01.1 Reimbursement and shared maximum

Preventive and basic dental is paid at 90% of the eligible dental fee, with no deductible. Basic and major services share one $1,750 payable maximum per person per calendar year. Orthodontics has a separate lifetime maximum. Eligible fees are the lower of the actual charge and the prior calendar year's general-practitioner dental fee guide for the employee's province of residence. Specialist charges use the general-practitioner guide, not a separate specialist schedule.

Service	Frequency or restriction
Recall examination and routine polishing	Once every 9 months
Scaling and root planing	8 units combined per calendar year
Routine bitewing radiographs	Once every 12 months
Complete oral examination	Once every 36 months
Panoramic or full-mouth radiographs	Once every 36 months, combined
Fluoride and pit-and-fissure sealants	Children under 16
Fillings, extractions and root canals	Medically necessary; shared annual maximum
Emergency examination	Not subject to routine recall interval

D01.2 Treatment rules

One scaling unit is 15 minutes. A service may be clinically recommended more often than the plan pays for it. The recall interval is measured between service dates and is not reset on January 1. Replacing an existing filling within 24 months is excluded unless new decay or accidental breakage is documented.

Tooth-coloured fillings are eligible, but posterior restorations are limited to the eligible fee for the basic equivalent restoration. Whitening, decorative attachments and cosmetic reshaping are excluded. Services that would be paid by a public programme are not paid again.

D01.3 Estimates and example

Send a treatment estimate before any proposed dental treatment over $500. A predetermination is not a reservation of the annual maximum. Claims paid before the planned treatment can reduce the balance available.

Example: a dentist bills $220, but the eligible guide fee is $200. The plan pays $180 at 90%, leaving $40 to the member. The $180, not the $220 invoice or $200 eligible fee, consumes the shared $1,750 dental maximum. The late-applicant restriction in G01 can impose a lower first-year cap.

D02 Major dental services

D02.1 Covered major procedures

Crowns, bridges, inlays, onlays and dentures are paid at 50% of the eligible fee, with no deductible. They share the $1,750 annual payable maximum with D01 basic dental. Major dental begins after 12 consecutive months of dental coverage. For coverage starting April 1, 2027, major services first become eligible on April 1, 2028. A02 contains a limited accidental-injury exception, not a general waiver.

Procedure	Replacement or eligibility condition
Crown or onlay	Tooth cannot be adequately restored by a basic filling
Fixed bridge	Missing tooth was extracted while covered, subject to A02
Full or partial denture	Necessary functional replacement
Replacement crown, bridge or denture	Existing appliance at least 5 years old and unserviceable
Implant	Fixture and surgery excluded; alternative benefit may apply
Denture repair	Basic dental at 90%, within annual pool

D02.2 Alternative benefit

When several procedures can provide a functional result, payment is based on the least costly suitable insured procedure. An implant-supported crown may receive an alternative benefit based on an eligible conventional bridge or denture, but implant surgery and the fixture remain excluded. Obtain a written predetermination showing the eligible alternative amount; the mere existence of a less costly option does not guarantee payment.

The base plan excludes initial replacement of a tooth missing before dental coverage began. It also excludes replacement solely to improve appearance, duplicate appliances and appliances lost through ordinary misplacement. A02 changes the pre-existing missing-tooth rule only for a specified documented accident after enrolment.

D02.3 Completion date and laboratory fees

A crown is incurred when permanently seated; a denture when delivered. Preparation and impression dates do not establish eligibility. Reasonable itemized laboratory fees form part of the eligible procedure amount and receive the same 50% rate and annual cap. In this specimen, laboratory fees are eligible up to 30% of the guide procedure fee.

Example: a crown has a $1,200 eligible procedure amount plus $240 eligible laboratory cost. The calculated benefit is $720. If basic dental has already used $1,300 that year, only $450 remains, so the actual payment is $450.

D03 Orthodontic treatment

D03.1 Child orthodontics

Orthodontics is paid at 50% with a $2,000 lifetime payable maximum per eligible dependent child. There is no deductible. Treatment must begin before the child's 19th birthday and after 12 consecutive months of dental coverage. Adult orthodontics is excluded. A student who qualifies as a dependant until 25 does not thereby qualify to start orthodontic treatment after age 18.

An approved course that begins while eligible may continue until completed or the child's 21st birthday, whichever occurs first, provided the child remains enrolled and otherwise eligible. Coverage also stops if the employee's dental benefit terminates. It is not continued solely because an orthodontist's contract remains unpaid.

D03.2 Payment schedule

Submit the diagnosis, proposed appliance, total fee, deposit, monthly instalments, anticipated duration and treatment start date before appliances are placed. Aligners and conventional braces are assessed under the same rules. Payment is based on eligible treatment charges as incurred rather than the entire contract price on signing.

Charge	Payment treatment
Initial appliance placement	Up to 25% of total contract fee recognized initially
Remaining treatment	Allocated over scheduled treatment months
Retainer included in original contract	Uses the same lifetime maximum
Lost retainer replacement	Excluded
Cosmetic treatment without functional indication	Excluded

D03.3 Example and transfer of care

For an eligible $6,000 contract with a $1,500 initial charge, the first payment is $750. If the remaining $4,500 is allocated over 18 months, each month's eligible fee is $250 and the ordinary payment is $125. Only $1,250 of lifetime benefit remains after the initial payment, so ten full monthly payments exhaust the $2,000 limit. Subsequent eligible fees receive no further payment under this plan.

If treatment moves to another orthodontist, submit the revised schedule and previous payment history. The lifetime limit does not restart. Discounts reduce the eligible contract price. A treatment interrupted before completion must be reconciled to services actually provided; payment for unperformed services is recoverable.

The employee's own braces are not covered under D03, although an eligible expense may be considered under the separate A03 health spending account balance.

T01 Emergency travel medical

T01.1 Eligible trips

Employees and enrolled dependants under 75 are covered for emergency medical expenses during the first 30 consecutive days of an eligible trip outside their home province, including travel outside Canada. Provincial coverage must remain in force. Reimbursement is 100% of eligible expenses with no deductible, up to $2,000,000 payable per person per trip. The departure date is day 1.

A trip planned for 40 days is covered only through day 30 under this plan; days 31 through 40 are not covered. No top-up is offered by this fictional group plan. Coverage ends earlier if enrolment ends or the person turns 75. Commuting across a provincial boundary for ordinary work is not a trip for this benefit.

T01.2 Emergency definition

An emergency is an unexpected illness or injury requiring immediate treatment to prevent serious harm. Eligible expenses include hospital accommodation, physician services, emergency diagnostics, prescribed emergency medication and medically necessary ambulance transportation. Planned treatment, routine monitoring and continuation of care after the emergency has ended are not emergency expenses.

Expense within the trip maximum	Payable sublimit
Emergency dental pain relief	$500 per trip
Injury to natural teeth	$2,000 per trip
Return of remains	$10,000 per trip
Emergency return of dependent children	$5,000 per family per trip
Approved bedside visit transport	$3,000 per trip

T01.3 Stable pre-existing conditions

A pre-existing condition is eligible only if stable throughout the 90 days before departure. Stable means no new or worsening symptoms, no new treatment or medication, no dosage change and no investigation awaiting results. A routine dose adjustment of insulin without deterioration does not alone break stability under this specimen rule. All other medication changes do.

Example: departure on June 1 requires stability throughout the 90 days before June 1. A medication change 45 days before departure means expenses arising from that condition are excluded. An unrelated accidental injury may still qualify. Stability does not remove other exclusions or the trip-duration limit.

T02 Travel assistance and exclusions

T02.1 Contact and authorization

Contact the assistance administrator as soon as reasonably possible and within 48 hours of emergency admission, unless the member is medically incapable and no representative can call. In a real emergency, obtain necessary care first. This fictional booklet supplies no operational emergency number. The demonstration contact is assistance@northstar-demo.example; do not send a real emergency request there.

The assistance team must approve evacuation, repatriation, air ambulance and transport for a bedside visitor before arrangements are made, except where immediate transport is essential to preserve life. They may select a medically appropriate provider or arrange a safe return to the home province. Unapproved convenience upgrades are excluded.

T02.2 What is not covered

Excluded expenses include travelling primarily to obtain treatment, routine pregnancy care, elective procedures, professional competitive sports and participation in armed conflict. Pregnancy-related emergencies are eligible before the end of week 32; childbirth and related expenses from week 33 onward are excluded. These are invented plan restrictions, not advice on the safety of travel.

Trip cancellation, lost baggage, rental car damage and flight delay are not insured. Treatment caused by a condition that fails T01 stability is excluded even if no diagnosis was made before departure. Expenses after the person is medically fit to return are excluded if the person refuses an approved return arrangement without medical justification.

T02.3 Claims and overlapping benefits

Keep medical records, itemized invoices, proof of departure and return, provincial plan statements and proof of payment. Submit the travel claim within 90 days after the return date. Amounts in foreign currency are converted using the exchange rate on the actual payment-card statement; without that evidence, use the fictional administrator's recorded service-date conversion rate.

The administrator first seeks available provincial reimbursement and then determines the balance under this benefit. No expense is paid twice under travel, routine health or a spouse's plan. A hospital may request payment before coverage is confirmed; an assistance file being opened does not guarantee that a claim will be accepted.

A student residing in another province to attend school is not automatically covered there as a perpetual traveller. The 30-day limit still applies unless a specific written student extension has been issued. No such extension is included in this booklet.

L01 Life and accidental loss benefits

L01.1 Basic and dependent life

Employee basic life equals two times annual base salary, rounded up to the next $1,000, with a $250,000 maximum. Salary excludes bonuses, overtime, commissions and expense allowances. At age 65, the amount reduces to 50% of the amount otherwise calculated. Coverage ends at retirement or age 70, whichever occurs first.

Dependent life is $10,000 for a covered spouse and $5,000 for each eligible child, from birth. Dependent life ends when the employee's basic life ends or the dependant stops qualifying. It is payable to the employee, while employee basic life is payable to the designated beneficiary or, if none is valid, the employee's estate.

L01.2 Accidental death and dismemberment

Employee AD&D has the same principal sum as employee basic life. It covers listed loss caused directly by an accident and sustained within 365 days of that accident. Illness, intentional self-injury and loss caused by excluded armed conflict are not insured under AD&D. These exclusions do not automatically apply to ordinary basic life.

Accidental loss	Percentage of principal sum
Death	100%
Both hands, both feet or sight in both eyes	100%
One hand and one foot	100%
One hand, one foot or sight in one eye	50%
Thumb and index finger of one hand	25%

Payments for losses from one accident cannot exceed 100% of the principal sum. If accidental death occurs after a partial loss payment from that accident, only the remaining principal sum is payable. Basic life and AD&D can both pay for a qualifying accidental death.

L01.3 Designations and example

Update the beneficiary after family changes. A change takes effect when recorded by the administrator, subject to any valid irrevocable designation. Optional life insurance is not included in this plan and cannot be inferred from the basic amount.

Example: base salary of $82,400 produces $164,800 before rounding and $165,000 of basic life. AD&D is also $165,000. At age 65, each becomes $82,500 if salary is unchanged. The plan does not re-round the reduced amount.

DI01 Short term disability

DI01.1 Benefit and waiting period

Short term disability replaces 70% of weekly base earnings, to a maximum of $1,200 per week. The employer pays the premium; payments are treated as taxable income for this fictional plan. Disability must prevent you from performing the essential duties of your own occupation because of illness or injury, while under appropriate professional care.

For illness, payment starts on day 8 after seven consecutive calendar days of disability. For accidental injury, payment starts on day 1. Benefits end no later than day 119 after disability begins, counting the waiting period. A partial week is paid at one-seventh of the weekly rate for each eligible calendar day.

Claim requirement	Time limit
Notify employer of absence	As soon as practicable
Initial employee and clinician forms	Within 30 days of disability onset
Initial proof deadline	Within 90 days of disability onset
Updated medical information	When reasonably requested

DI01.2 Offsets and exclusions

Payments are reduced dollar for dollar by workers' compensation, employer salary continuation and other employer-funded disability benefits for the same period. Ordinary investment income does not reduce payment. Disability arising from an occupational injury is excluded where a workers' compensation benefit is payable. Parental leave, lack of childcare and unemployment are not disability. Pregnancy complications are evaluated using the same functional standard as other illnesses.

You must participate in a reasonable documented rehabilitation or gradual-return programme. Earnings during approved partial work reduce the weekly benefit by 50% of those earnings, subject to total income from work and disability not exceeding pre-disability weekly base earnings. No disability payment is made for a day of full return to regular duties.

DI01.3 Recurrent disability and example

A recurrence from the same or related condition within 14 days after returning to full duties continues the previous claim and does not restart the day-119 limit. A later recurrence is a new claim with a new waiting period.

For $78,000 annual base salary, weekly base earnings are $1,500 using 52 weeks. The weekly benefit is $1,050 before offsets and tax. An illness beginning on a Monday begins payment the following Monday if all conditions remain satisfied.

DI02 Long term disability

DI02.1 Amount and start date

Long term disability begins on day 120 after 119 consecutive days of qualifying disability. It replaces 66.67% of monthly base earnings, to a maximum of $5,000 per month. The employee pays the entire LTD premium. For this fictional plan, benefit payments are described as non-taxable. This specimen treatment is not tax advice for any real arrangement.

During the first 24 months of LTD payments, disability means inability to perform the essential duties of your own occupation. After that period, it means inability to perform an occupation for which you are reasonably qualified by education, training or experience and which could provide at least 60% of indexed pre-disability base earnings.

DI02.2 Duration and limitations

LTD ends when disability no longer meets the definition, the member turns 65 or the member dies, whichever occurs first. A disability beginning at or after age 65 is not covered. Income loss caused only by dismissal, a professional licence suspension or the employer's lack of suitable work is excluded.

The pre-existing-condition limitation applies during the first 12 months of LTD coverage. A condition is pre-existing if the member received treatment, consultation or prescribed medication for it in the 90 days before LTD coverage began. Disability caused by that condition during those first 12 months is excluded. The limitation does not apply after 12 months of continuous LTD coverage.

DI02.3 Offsets and rehabilitation

CPP or QPP disability benefits paid to the member, workers' compensation and other employer disability income reduce LTD dollar for dollar. CPP benefits paid to dependent children do not reduce LTD under this plan. Approved rehabilitative earnings reduce LTD by 50% of those earnings, with a combined income ceiling of 100% of indexed pre-disability monthly base earnings. Other offsets are applied before the rehabilitation adjustment.

Proof of continuing disability and participation in appropriate care are required. A recurrence within six months after returning to full duties continues the prior LTD claim without a new elimination period. It does not restart the 24-month own-occupation period.

Example: monthly base earnings of $6,000 produce $4,000.20 before offsets. A $1,200 CPP disability payment reduces LTD to $2,800.20. No salary increase after disability begins changes the insured base earnings. There is no automatic cost-of-living increase to the LTD payment itself.

A03 Spending accounts and assistance

A03.1 Health spending account

The employer credits $750 per employee each January 1 to a family-shared health spending account. New eligible employees receive $62.50 for each remaining month of the year, including the month their coverage begins. No employee contribution is required. Eligible dependants use the same balance; they do not each receive $750.

The account reimburses approved unreimbursed medical and dental expenses at 100% up to the available balance. For this fictional plan, eligible categories are prescription drugs, licensed dental treatment, prescription eyewear, eligible registered-practitioner treatment and prescribed medical devices. It may pay member shares above insured limits and adult orthodontics. It cannot pay cosmetic whitening, gym fees, missed appointments or amounts reimbursed elsewhere.

A03.2 Carryforward and claim timing

Unused credits carry forward for one calendar year only. Use the oldest credits first. Unused 2027 credits expire on December 31, 2028. Unpaid expenses do not carry forward: an expense incurred in 2027 must use credits available for 2027 and be submitted by March 31, 2028. Submission during that grace period does not allow use of the new 2028 credit for a 2027 expense.

Example: $200 left from 2027 plus the $750 credit for 2028 gives $950 for eligible 2028 expenses. If $100 is spent in 2028, it consumes the old credit first. The remaining $100 old credit expires at the end of 2028; any unused new credit can carry into 2029.

A03.3 Wellness and employee assistance

Programme	Benefit	Distinctive rule
Wellness spending account	$300 per employee per year	No dependants and no carryforward
Employee assistance	6 sessions per issue per household	Must be arranged through the programme
Virtual primary care access	Unlimited platform consultations	Prescriptions and tests are not automatically paid

The wellness account covers fitness memberships, exercise classes and sports registration. It is described as taxable in this specimen. Submit wellness expenses by March 31 following the expense year. Assistance services offer short-term counselling and referrals, not disability certification or a guarantee of insured reimbursement. Their session allowance is separate from P02.

C01 Claims and reimbursement

C01.1 Ordinary claims

Submit health, drug, therapy, vision and dental claims within 12 months after the service date. Following termination of coverage, submit expenses incurred while covered within 90 days after termination or within the ordinary 12-month period, whichever ends earlier. Spending-account and travel deadlines are different and are stated in A03 and T02.

A claim should identify the member, patient, group number, service date, provider, service description, amount charged and any payment from another plan. Attach an itemized receipt showing payment. A card transaction alone does not identify the treatment and is not sufficient. Keep original receipts for 24 months after submission in case verification is requested.

C01.2 Approval and direct billing

Direct billing is available only if a provider participates in the fictional network. A direct-billing acceptance message is an initial processing result, not a waiver of policy conditions. If an overpayment is identified later, the administrator may recover it from future reimbursements after explaining the reason and amount.

Claim type	Typical supporting document
Prescription drug	Pharmacy receipt and drug identification number
Massage before July 1, 2027	Receipt, registration number and prior referral
Custom orthotics	Prescription, fabrication record and invoice
Major dental	Procedure codes, guide fee and treatment estimate
Orthodontics	Approved treatment contract and monthly schedule
Vision	Prescription and dispensing receipt

C01.3 Decisions and review

An explanation of benefits shows billed expense, eligible expense, reimbursement rate, deductible, amount paid, maximum used and any reason for decline. A declined claim may be appealed within 90 days after the decision. Include the claim identifier, disputed reason and additional evidence. Filing an appeal does not authorize treatment or extend coverage.

The fictional service target is ten business days after receipt of complete ordinary claims and thirty business days for a first-level appeal. These are administrative targets, not guaranteed payment dates. Complex claims may require more information. Disability claims have their own evidence requirements; submit them early enough to avoid a gap between short and long term benefits.

Never submit real member identifiers or medical records to the example addresses in this demonstration booklet.

C02 Coordination with other plans

C02.1 Which plan pays first

Submit your own expenses to the plan covering you as an employee before a plan covering you as a spouse. Your spouse uses their employee plan first. For a dependent child covered by both parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first; the year of birth does not matter. A parent born in February is first before a parent born in October even if the October parent is older.

If parents have the same birthday, the plan covering a parent for longer is first. Where parents are separated, this specimen first follows a documented court allocation; without one, it applies the custodial parent's plan, then that parent's spouse's plan, then the other parent's plan. Send the relevant information instead of assuming the birthday rule always applies.

C02.2 Secondary payment rule

This specimen uses a defined secondary rule for consistent demonstrations: calculate what this plan would pay independently, then pay the lesser of that amount and the eligible expense still unpaid after the primary plan. Remaining limits and exclusions still apply. Secondary payment cannot exceed the remaining annual or lifetime maximum.

Example component	Amount
Eligible physiotherapy expense	$120
Primary spouse plan payment	$60
This plan's independent 80% calculation	$96
Remaining unpaid eligible expense	$60
This plan's secondary payment	$60

C02.3 Order of submissions

Send the primary plan's explanation of benefits with the secondary claim. After both plans process the claim, a remaining eligible amount may be sent to the health spending account. Do not send the full invoice to the account before reporting the other payments. The account is a final payer under this plan.

Amounts above this plan's eligible fee can remain unpaid even when the total billed amount has not been reimbursed. A secondary plan is not required to pay an excluded cosmetic service. The combined-payment ceiling prevents overinsurance; it does not promise reimbursement of every bill.

When a primary plan later changes its payment, report the adjustment. The secondary calculation and account payment must be recalculated. Refunds or discounts from the provider also reduce the net eligible expense.

G04 Leave and end of coverage

G04.1 Temporary absences

During an approved paid leave, existing coverage may continue while required contributions are maintained. During an approved unpaid personal leave, health, dental and life may continue for up to 90 days if arranged before leave and contributions are paid. Disability coverage does not continue during unpaid personal leave; a new disability beginning during that leave is not insured. A disability claim that began before leave remains governed by DI01 or DI02.

For statutory family or parental leave, the employer will confirm continuation consistent with the applicable leave arrangement. This fictional booklet does not state or replace real employment-law requirements. Obtain the continuation dates in writing rather than assuming the 90-day personal-leave rule applies to every type of absence.

G04.2 Termination dates

Benefit	Ordinary termination trigger
Extended health, vision and dental	Last day of month employment ends; otherwise age 75 or loss of eligibility
Emergency travel	Earlier of health termination and age 75
Basic life and AD&D	Last day of employment, retirement or age 70, whichever first
Short term disability	Last day actively employed; no new claim after age 65
Long term disability	Last day actively employed or age 65, whichever first
Spending accounts	Last day of employment for new expenses

A death during employment permits covered dependants to continue health, dental and travel for 24 months without contribution, unless eligibility ends sooner or equivalent employer coverage begins elsewhere. Life and disability benefits do not continue under this survivor provision. Spending accounts are not replenished for survivors.

G04.3 Conversion and runout

Employee basic life may be converted without new medical evidence by applying within 31 days after termination, up to the lesser of $100,000 and the amount lost. The available individual product and premium would be confirmed separately; no real conversion product exists in this specimen. There is no individual dental conversion option.

Ordinary health and dental runout is 90 days as described in C01. Spending-account expenses incurred before termination must also be submitted within 90 days, even if the usual March 31 deadline would be later. Runout permits submission of old expenses, not new treatment after coverage ends. A treatment estimate approved before termination does not extend the service date eligibility.

G05 Exclusions and interpretation

G05.1 General expense exclusions

The plan excludes services not actually provided, false receipts, duplicate claims, cosmetic procedures unless specifically included, missed-appointment charges, administrative form fees and expenses paid by a government programme or another payer. It excludes services from the member, the member's spouse or an immediate family member, even if professionally qualified. A recommendation by a physician does not override an express exclusion.

Experimental services are excluded unless specifically approved in writing as an exception. For this specimen, experimental means not authorized for the proposed use by the applicable Canadian regulator or supplied only as part of a research protocol. A drug may nevertheless qualify for an expressly approved off-label exception if RX02 authorization identifies that use; no such approval should be inferred from a general prescription.

G05.2 Benefits do not combine automatically

A therapy maximum, a drug maximum and a spending-account balance are distinct. Unused dental coverage cannot be transferred to massage. Unused vision allowance cannot be used for routine eye drops. The same expense is considered under the most specific applicable benefit; if overlapping benefits could apply, payment cannot exceed the expense and the same amount does not consume two pools.

Where terms conflict, apply the following order: the specific dated amendment, the detailed benefit section, the general rules, and finally a summary or worked example. A clerical error in an example does not change coverage. The governing text for this fictional plan is this complete booklet; there is no undisclosed master contract needed to answer its demo questions.

G05.3 Review of information

The administrator may request proof of age, dependant status, provider credentials or service details. Failure to supply necessary evidence can delay a decision. Intentional false statements may cause claim denial and recovery of overpayments. Corrections to innocent administrative errors are assessed using the person's actual eligibility and the documented service date.

All reimbursement caps, dates and requirements in this booklet are deliberately invented. They are internally defined test rules, not representations of any Canadian insurer's standard coverage. A demo system should not apply them to another employer, another class, another booklet edition or a real patient's insurance.

In a real setting, obtain coverage confirmation from the actual insurer before treatment. This sample cannot establish an entitlement to a health service, provide financial protection or act as evidence of insurance.

A01 and A02 Amendments

A01 Massage enhancement from July 1 2027

Effective for massage services incurred on or after July 1, 2027, the maximum in P01 increases from $500 to $750 payable per person per calendar year. Reimbursement remains 80%. No health deductible applies. A physician referral is no longer required for those service dates. The registered-massage-therapist credential requirement remains unchanged.

All massage payments for services earlier in the same calendar year count toward the revised $750 total. Claims for services before July 1 remain subject to the old $500 cap and referral rule, even if received after July 1. The revised maximum and no-referral rule continue in later years unless another amendment replaces them.

Example: $500 has been paid for January through June. A qualifying $150 July session produces $120 reimbursement, leaving $130 of the $750 annual maximum. A June session submitted in August still needs the pre-service referral and cannot use the increase to recover amounts excluded by the old $500 cap.

A02 Accidental dental exception

Effective January 1, 2027, the 12-month major-dental waiting period in D02 is waived for restoration of a natural tooth damaged in a sudden external accident after that person's dental coverage starts. Treatment must be completed within 180 days after the accident and while dental coverage remains in force. Biting or chewing, ordinary decay and gradual breakage are not external accidents.

The missing-tooth exclusion is waived only when the tooth was present when dental coverage began and was then lost in that qualifying accident. It is not waived for a tooth missing before enrolment. This clarification permits an accident-related bridge within the conditions above; it does not cover elective replacement of an older missing tooth.

Term	Changed by A02?
Major-dental 12-month waiting period	Yes, qualifying accidental restoration only
Major reimbursement rate	No; remains 50%
Shared annual dental maximum	No; remains $1,750
Orthodontic waiting period	No
Late-applicant $250 restriction	No

Travel dental treatment that qualifies under T01 is considered there first. The same invoice cannot also be reimbursed under A02 beyond any remaining eligible expense. These amendments replace only the expressly stated rules; all other limitations remain in force.

X01 Worked benefit examples

X01.1 Massage after the change

Sam has received $480 for massage services before July 1, 2027. In August, Sam attends two $150 visits. At 80%, each produces $120. The plan pays $240 total and cumulative massage payments become $720, leaving $30. A third identical August visit would pay only $30. No referral is needed for these August visits. The answer requires both P01 and A01.

X01.2 Different dental categories

Alex uses $900 of the shared annual dental maximum on basic treatment, then completes a crown after satisfying the major-service waiting period. The crown's total eligible fee is $1,600. At 50%, payment is $800. The annual balance before the crown is $850, so the full $800 is payable and $50 remains. The major benefit is not a separate $1,750 pool.

X01.3 Child braces and student status

Riley is an eligible 20-year-old full-time student who wants to start braces. D03 declines a new course because treatment must begin before age 19. G02 student eligibility does not override that age limit. If an approved course had begun at 18, it could continue only under D03's continuation rules, including the age-21 end date and remaining lifetime allowance.

X01.4 Vision and remaining allowances

Morgan is an adult who received $240 for glasses on February 5, 2027. On December 10, 2027, Morgan buys $200 contacts. With no other eyewear claims, the plan pays $60. The next January 1 does not restore $300 because adult eyewear uses a rolling interval. The February payment drops out on February 5, 2029, but the December payment stays in the lookback until December 10, 2029.

X01.5 Mental health and assistance

Taylor uses all six programme-arranged assistance sessions for one issue, then receives four $180 private sessions from a registered psychotherapist. The assistance sessions do not consume P02. The insured mental health payment is $720, leaving $1,280 of the combined annual mental health pool. This assumes no other psychologist, social-worker or assessment claims.

X01.6 Travel duration

Casey plans a 35-day holiday and has a stable pre-existing condition. An unrelated eligible emergency on day 12 can be covered. An emergency beginning on day 32 is outside the 30-day benefit even if the person remains enrolled and the medical condition is stable. Stability, enrolment and duration are separate tests.

X02 Definitions and quick reference

X02.1 Key terms

Eligible expense means the portion of a bill that meets the benefit's service, fee and timing rules before the reimbursement percentage is applied. Reimbursement percentage is the share of that eligible amount payable after any applicable deductible. A payable maximum is the most the plan will actually pay over the stated interval.

A deductible is an amount deducted from otherwise eligible expense before the percentage is applied. A sublimit is a smaller cap within a larger pool, not an additional allowance. A combined maximum is shared by the listed services. A waiting period delays the start of eligibility for a benefit; an elimination period delays disability payments after disability begins.

Calendar year means January 1 through December 31. Rolling interval means the relevant number of months measured back from each service date. Lifetime means cumulative coverage under this fictional plan without annual reset. Prior authorization is written approval of a proposed service or medication before the expense, subject to its stated period and conditions.

X02.2 Frequently confused rules

Question	Rule and source
Is massage $750 for every therapist?	No; one massage pool per person, P01 and A01
Do all therapies share one maximum?	No; only explicitly combined categories share, P01
Is counselling 80% like physiotherapy?	No; qualifying counselling is 100%, P02
Do crowns have their own annual pool?	No; basic and major share $1,750, D01 and D02
Does dental cover adult braces?	No insured orthodontics; HSA may help, D03 and A03
Can travel pay for cancelled flights?	No trip cancellation benefit, T02
Do family members each get $750 HSA?	No; one family-shared employee balance, A03
Does a claim deadline extend coverage?	No; runout is for earlier eligible expenses, G04

X02.3 Using this specimen

For a coverage question, identify the patient, age, service date, expense type, billed amount, prior payments, enrolment date and any other plan. If a required fact is missing, the result should be conditional rather than inventing that fact. Cite the section and any amendment supporting the answer.

For a claim estimate, state the eligible fee, deductible, reimbursement percentage, remaining maximum and final payment separately. For exclusions or missing information, explain which rule prevents a definite payment estimate. Do not confuse an example person's history with the user's history.

End of fictional employee benefits booklet. SAMPLE ONLY - NOT VALID INSURANCE.