Details of Covered Benefits

PRESCRIPTION DRUGS

Reimbursement Percentage

70% of the ingredient cost.

Annual Maximum per Insured Person

BENEFIT – Year One - $1,000, Year Two - $2,000, Subsequent Years - $3,000

Senior Members and Provincial Government Prescription Drug Plans

After age 65, most senior Members will have many of their prescription drug costs paid through their provincial government's prescription drug plan. As some provinces require registration, senior Members (prior to reaching their 65th birthday), are encouraged to contact their provincial program or speak to their health care practitioner about any registration requirements; some provinces will require annual re-application. When a new prescription medication is being prescribed, senior Members may want to ask their pharmacist if it is covered under the provincial plan. If the medication is not covered, it may be appropriate to discuss possible options or alternatively submit a Special Authorization Request Form in order to determine if the prescription medication is covered under the AFBS formulary.

For assistance, please contact AFBS at 1.855.934.2355.

Members Residing in Quebec

For Members residing in Quebec, the requirements of the Régie de L'Assurance Maladie du Québec (RAMQ) will apply.

Eligible Prescription Drugs

A wide range of drugs which can be purchased on the written prescription of a Medical Doctor, dentist or nurse practitioner within the legislated scope of their practice are covered under the AFBS prescription drug managed formulary. A managed formulary means that every new prescription drug is evaluated by clinical pharmacists and a determination made as to its inclusion within the AFBS plan.

The evaluation results in each drug being placed within the general formulary or being available only when certain criteria are met, which is called Special Authorization, or being excluded from coverage. While the prescription drugs within the AFBS formulary do change from time to time, the following highlights the number of drugs which are available under each category.

General Formulary - 9,500 DRUGS, Special Authorization - 450 DRUGS, Excluded - 50 DRUGS

AFBS Formulary

The AFBS formulary is also referred to as a generic drug plan. This means that when there is a generic drug that is interchangeable with a brand-name drug, the amount covered by AFBS will be based on the ingredient cost of the generic alternative. Normally, pharmacists will dispense the generic drug, however, you may wish to ask your doctor or pharmacist if there is a generic alternative at the time your prescription is being written or dispensed. If you choose to purchase the more expensive brand-name drug, you will be responsible for the full cost difference between the generic drug ingredient cost and the brand-name drug ingredient cost regardless of a 'no substitutions' indication on the prescription slip. The AFBS formulary continues to cover brand-name drugs when there is no interchangeable generic available or in those occasional situations where a Member has an adverse reaction to a generic drug and medical confirmation is on file with the clinical pharmacists.

Details of Covered Benefits

PRESCRIPTION DRUGS – NOT COVERED

- HIV/AIDS and multiple sclerosis medications are coordinated through your provincial health plan and are not eligible for reimbursement under the general AFBS formulary.
- Non-prescription drugs, over-the-counter medications and prescription drugs not included on the AFBS formulary are excluded from reimbursement.
- Dispensing fees.
- Atomizers, aero chambers, vaporizers, diagnostic aids.
- Infant formula.
- Vitamins (except injectibles when not used in conjunction with weight loss).
- Dietary food/supplements, aids, minerals, or electrolyte replacements whether prescribed or not, except by law where a prescription is required for their sale.
- Rogaine and all other topical preparations of Minoxidil.
- Drugs not approved for sale by Health Canada.
- Drugs not considered to be therapeutically useful by the Canadian Medical Association or by the medical association of the Insured Person's province of residence.
- Investigational or emergency release drugs.
- All materials used for contraception, except orally administered contraceptives.
- More than the customary supply of drugs prescribed by a physician or dentist or a 34-day supply, whichever is less, except maintenance drugs where a 90-day or 100-day supply may be dispensed.

Details of Covered Benefits

EXTENDED HEALTH CARE – VISION/PARAMEDICAL CARE

Reimbursement Percentage

70%

Annual Maximum per Insured Person

BENEFIT – Year One - $500, Year Two - $500, Subsequent Years - $750

BENEFIT – Vision Care (includes eye examination by an Optometrist or Ophthalmologist, prescription eyeglasses or contact lenses and laser eye surgery). Does not cover prescription sunglasses.

LIMITATIONS – $325 every two Benefit Years.

BENEFIT – Registered Psychologist, Chiropractor, Naturopath, Homeopath, Chiropodist, Podiatrist, Osteopath

LIMITATIONS – Maximum of $45 per visit.

BENEFIT* – Registered Massage Therapist, Traditional Chinese Medicine, Acupuncturist, Dietician

LIMITATIONS – Maximum of $45 per visit.

EXTENDED HEALTH CARE – OTHER SERVICES AND SUPPLIES

Reimbursement Percentage

70%

Annual Maximum per Insured Person

BENEFIT – Year One - $7,500†, Year Two - $7,500†, Subsequent Years - $7,500†

†Maximum includes benefits paid for Vision/Paramedical Care.

BENEFIT – Emergency ground Ambulance transportation to Hospital

LIMITATIONS – Reimbursement is based on any co-payment amount required by your province of residence. Scheduled use of ambulance services is not covered. This benefit is not available outside of your province of residence.

BENEFIT – Air Ambulance

LIMITATIONS – Maximum of $4,000 when not paid by the Insured Person's provincial plan. Only payable for flights originating and terminating within your province of residence.

***** *This symbol indicates that a written recommendation from your Medical Doctor must be submitted specifying the condition for which treatment is being prescribed. This written recommendation must be provided each Benefit Year and before any benefit is paid.* ***Special note:*** *With respect to massage therapy and acupuncture, a written recommendation can be provided every three Benefit Years.*

Details of Covered Benefits

EXTENDED HEALTH CARE – OTHER SERVICES AND SUPPLIES

BENEFIT* – Private Duty Nursing following hospitalization and when medically required for ongoing recovery or when required for in-home palliative end-of-life support. Excludes cosmetic surgery or procedures.

LIMITATIONS – Maximum of $2,500. Requires pre-approval by AFBS. The provider may be a licensed practical nurse (RPN), registered nurse (RN) or a registered nursing assistant (RNA). Reimbursement from AFBS is subsequent to any provincial plan coverage that may be available. Services must be put in place immediately following hospital discharge and may be extended over a period not exceeding 45 days. Excludes cosmetic surgery or procedures. This is not a long-term care benefit.

Palliative support is payable during one occasion only. Annual maximums will apply, however, the hospitalization and 45-day maximum requirements may be waived by AFBS.

BENEFIT – Hospitalization

LIMITATIONS – Reimbursed at 70% for first five days and 100% thereafter. Semi-private room only. Standard ward room costs are covered by your provincial health plan. Additional room costs are reimbursed for acute care only when provided by an accredited hospital. The room costs for hospitalization in an accredited hospital that provides physical rehabilitation services will be covered when this follows immediately after a minimum of three days of acute care. Room costs incurred in any of a convalescent, long term care, nursing home or a facility which primarily provides treatment for addiction(s) are not covered. This benefit is not available outside of your province of residence.

BENEFIT* – Home Care following Hospitalization and when medically necessary for ongoing recovery

LIMITATIONS – Reimbursed at 70% up to a maximum of $30 each day for a maximum of 30 days each Benefit Year.

Requires pre-approval by AFBS, and the provider must be supervised by an organization recognized to provide such care. Services may be provided by an RPN, RN, RNA, Personal Service Worker (PSW), Victorian Order of Nurses (VON) or other health care provider as deemed appropriate by the insured's Medical Doctor and AFBS. Reimbursement to family members or companions will not be considered. Must be preceded by surgery (excluding cosmetic surgery) requiring at least one night of hospitalization or three days acute care hospitalization or following physical rehabilitation in a medical facility designated to provide these services. This home care benefit must be used within 90 days following discharge. Reimbursement from AFBS is subsequent to any provincial plan coverage that may be available.

BENEFIT* – Wigs

LIMITATIONS – Lifetime maximum of $1,000 only for cancer patients undergoing chemotherapy.

BENEFIT – Fertility Testing

LIMITATIONS – Lifetime maximum of $2,500.

BENEFIT* – Artificial Limbs and Eyes

LIMITATIONS – Maximum of $5,000 every five Benefit Years of continuous coverage. Reduced to three Benefit Years for a child under 18 years of age.

***** *This symbol indicates that a written recommendation from your Medical Doctor must be submitted specifying the condition for which treatment is being prescribed. This written recommendation must be provided each Benefit Year and before any benefit is paid.*

Details of Covered Benefits

EXTENDED HEALTH CARE – OTHER SERVICES AND SUPPLIES

BENEFIT* – Hearing Aids

LIMITATIONS – Maximum of $500/ear every four Benefit Years, or every two Benefit Years for a dependant child under age 18.

BENEFIT – Orthotics

LIMITATIONS – Reimbursed at 70% up to a maximum of $150 per benefit year. Orthotics must be prescribed by one of: Medical Doctor (MD), Podiatrist (DPM), Chiropodist (D CH or D Pod M). Further, the product must be dispensed by one of the following providers and include the biomechanical assessment as well as an itemized receipt listing all the items and modifications. Recognized providers are: Orthotist (CO or CPO(c)), Pedorthist (C Ped(c) or C Ped (MC)), Podiatrist (DPM), Chiropodist (D CH or D Pod M). Both the name and qualifications of the prescribing specialist and provider must be clearly noted.

BENEFIT* – Physiotherapist

LIMITATIONS – Maximum of $750 each Benefit Year.

BENEFIT – Special vision care benefit after cataract surgery

LIMITATIONS – 70% with a lifetime maximum of $500/eye. Includes payment towards a corrective lens, contact lens or prosthetic lens. Any laser vision follow-up is excluded. Confirmation of surgery is required. This benefit is payable in addition to any vision care benefit payable.

BENEFIT* – Audiologist, Speech Therapist

LIMITATIONS – Combined maximum of $750 each Benefit Year.

BENEFIT* – Medical Equipment

LIMITATIONS – **Hospital Bed** – Rental or purchase to lifetime maximum of $1,500.
Wheelchair – Rental or purchase to lifetime maximum of $1,000.
Oxygen Set – Rental or purchase.

BENEFIT – Accidental Dental

LIMITATIONS – Reimbursed at 70% of dental expense.

***** *This symbol indicates that a written recommendation from your Medical Doctor must be submitted specifying the condition for which treatment is being prescribed. This written recommendation must be provided each Benefit Year and before any benefit is paid.*

Details of Covered Benefits

EXTENDED HEALTH CARE – ASSISTIVE DEVICES

Assistive Devices** – The purchase or rental of assistive devices, mobility aids and medical equipment is limited to the items specified below.

BENEFIT	LIMITATIONS
Walker*	Covered up to the usual and customary.
Urethral Catheters	Covered up to the usual and customary.
Casts, Splints, Walking Canes, Crutches*, Truss	Covered up to the usual and customary.
Cervical Collar*	Covered up to the usual and customary.
Tracheostoma Tubes	Covered up to the usual and customary.
Colostomy and Ostomy Supplies Where Surgical Stoma Exists	Covered up to the usual and customary.
Blood glucose meter, continuous glucose monitor reader, insulin infusion sets, test strips and needles	Covered up to the usual and customary.
Abdominal, Back or Knee Brace*	Abdominal and back brace lifetime maximum of $500/each. Knee brace lifetime maximum of $500/knee.
CPAP (continuous positive airway pressure) Machine*	Lifetime maximum of $500.
IPPB (intermittent positive pressure breathing) Machine*	Lifetime maximum of $500.
Apnea Monitors for Respiratory Dysrhythmias*	Lifetime maximum of $500.
Light Therapy Where SADD is Diagnosed*	Lifetime maximum of $200.
CPAP and IPPB Supplies	Maximum of $100 per Benefit Year.
Devices and Medical Aids Necessitated After Surgery*	Maximum of $500/incident. Lifetime maximum of $2,500. Home renovations including lift bars, grab bars, and poles are excluded.
Tens Machine (transcutaneous nerve stimulator for chronic pain)*	Lifetime maximum of $500.
Support Hose and Compression Stocking	Maximum four pairs per Benefit Year.
Surgical Brassieres	Maximum two per Benefit Year.
Continuous glucose monitor starter kit (reader & initial sensors) (i.e. FreeStyle Libre Flash) Continuous glucose monitor sensors Available to insureds who use insulin to manage their blood/glucose levels	Maximum of once every three Benefit Years up to a maximum of $250. Maximum of $1,000 per Benefit Year.
Insulin Pump*	Lifetime maximum of $1,000.
External Breast Prosthesis (when required as a result of a total or radical mastectomy)	Maximum of one per Benefit Year.
Stump Socks	Maximum four pairs per Benefit Year.

** This symbol indicates that a written recommendation from your Medical Doctor must be submitted specifying the condition for which treatment is being prescribed. This written recommendation must be provided each Benefit Year and before any benefit is paid.*

*** For other assistive device items listed, AFBS may request a written medical recommendation with the initial claim submission and at its discretion.*

Details of Covered Benefits

EXTENDED HEALTH CARE – NOT COVERED

Services and supplies which are not specifically listed as a covered expense are not eligible for reimbursement through the Arts & Entertainment Plan. The following are also ineligible for reimbursement:

- Payment of the provincial health care premium.
- Services payable through any provincial hospital plan or provincial health care plan, WSIB/workers' compensation, other government agencies, other insurers or other sources.
- Medical Doctors' fees for completing claim forms or reports, missed appointments, or examinations to obtain insurance coverage.
- Standard hospital ward accommodation.
- Cosmetic surgery.
- Travel for health reasons or rest cures.
- Bodily injury resulting from war, insurrection or riot.
- Coverage for eligible dependants unless the Member has elected to insure them and paid the appropriate premium.
- Out-of-country/province bills for hospital or Medical Doctors' fees. Surgeries performed privately and outside of provincial health care plans.

Details of Covered Benefits

DENTAL CARE

Reimbursement Percentage

BENEFIT – Year One - 60%, Year Two - 60%, Subsequent Years - 60%

Annual Maximum per Insured Person

BENEFIT – *Basic Services*
Year One - $300, Year Two - $300, Subsequent Years - $500
– *Endodontic, Periodontal and Major Restorative Services*
Year One - $500, Year Two - $500, Subsequent Years - $750

The Plan Reimbursement is Based on Two Components

1) The dental services covered under the AFBS dental formulary; and
2) The current schedule of fees of the dental association of the province in which services are provided.

Reimbursement for dental services provided outside Canada is paid based on the current Ontario Dental Association fee guide.

BASIC SERVICES	LIMITATIONS
Complete examination and full series X-rays or panoramic films	Once every three Benefit Years or if a new dentist is involved in the Insured Person's dental care.
Recall examination by the dentist	Once every nine months.
Topical application of any anti-carcinogenic agent (e.g. stannous fluoride) or polishing of teeth	Once every nine months.
Routine diagnostic and laboratory procedures	Eligible laboratory fees are limited to a maximum of half the total cost of the dental procedure. Reimbursement is a percentage of the eligible fees.
Prophylaxis, including deep scaling	Ten units per Benefit Year. Pre-authorization for any additional units is required from the AFBS dental consultant.
Bitewing X-rays	Once per Benefit Year.
Oral hygiene instruction	Once per Lifetime.
Fillings (amalgam, silicate, acrylic and composite), Retentive pins and pit and fissure sealants	
Space maintainers	
Root canal therapy, root amputation, apexification and periapical services	
Oral surgical procedures including the removal of teeth	

Details of Covered Benefits

DENTAL CARE

PERIODONTAL, ENDODONTIC AND MAJOR RESTORATIVE SERVICES	LIMITATIONS
Periodontal Treatment of disease of the gums and other supporting tissue of the teeth (excluding splinting), including surgery and post-surgical treatment and appliances	Periodontal treatments are limited to once every 24 months per arch.
General anesthesia and X-rays	X-rays are limited to three per Benefit Year. General anesthetic is paid in conjunction with eligible oral surgical procedures.
Crowns, inlays and onlays	Only when the function is impaired due to cuspal or incisal angle damage caused by trauma or decay.
Replacement of crowns, inlays and onlays	Once every five Benefit Years.
Implants	Reimbursement may be limited to that of the generally accepted alternative and costs may not be applied across Benefit Years.
Initial provision for fixed bridgework	
Replacement of fixed bridgework or additional teeth to bridgework	When replacement or addition is due to one of the following: 1. A natural tooth is extracted and the existing appliance cannot be made serviceable. 2. The existing appliance is at least five years old and cannot be made serviceable. 3. The existing appliance is temporary and within 12 months of its installation a permanent bridge replaces it. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.
Initial provision of full or partially removable dentures	
Repair or re-cementing of crowns, onlays, inlays, bridgework and dentures, or relining and rebasing of dentures	
Replacement of removable dentures	When dentures are necessary due to one of the following: 1. A natural tooth is extracted and the existing appliance cannot be made serviceable. 2. The existing appliance is at least five years old and cannot be made serviceable. 3. The existing appliance is temporary and within 12 months of its installation a permanent denture replaces it. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for a permanent denture.
Addition of teeth to an existing partial denture or fixed bridgework previously removed	When required to replace one or more teeth.
Procedures involving the use of gold	Only when there is no alternative consistent with generally accepted dental practice.

Details of Covered Benefits

DENTAL CARE

PRE-DETERMINATION	LIMITATIONS
Some Expenses Require Pre-Determination	If your dentist recommends dental work that will cost more than $500 or includes procedures such as crowns, bridgework, veneers, implants, onlays or inlays, the proposed work must be reviewed by AFBS' dental consultant before any reimbursement can be made. When the pre-determination is done before you proceed with the actual dental treatment, you will have confirmation of the amount that will be reimbursed by AFBS. Your dentist will be familiar with the pre-determination process and must provide AFBS with specific information about the proposed work as well as X-rays, study moulds or casts. Please advise your dentist's office that pre-determination requests MUST be sent to AFBS. Pre-determinations sent elsewhere, including ClaimSecure, may not reach AFBS and will delay claims adjudication. Pre-determination is not necessary if treatment is the result of an emergency. If the emergency treatment is for a crown or bridge, you must submit X-rays with your claim. Pre-determination is not necessary for a crown if root canal has been performed on the tooth, however, the dentist should indicate this on the claim form.

DENTAL CARE – NOT COVERED

- Cosmetic dentistry, including dental bleaching.
- Replacement of lost, stolen or misplaced dentures.
- Prosthetic devices ordered prior to being insured.
- Prosthetic devices ordered while covered under the Plan but installed more than 60 days after the Insured Person is no longer covered under the Plan.
- Fees charged by a dentist that are in excess of the Dental Association Fee Guide in the province of residence of the Insured Person.
- Fees charged by a dentist for completion of a dental claim form, missed appointments, or for X-rays and study moulds required for pre-determination.

GROUP TERM LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

AFBS provides you with Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance. This is term insurance and is only in place while you are insured through this Plan. There is no paid-up or cash surrender value associated with this coverage.

Coverage Amount

Access to coverage and the amount of coverage is based on your age as indicated in the table below.

Age at Renewal	Group Term Life Insurance	AD&D Insurance
Under age 65	$10,000	$20,000
Ages 65 to 69	$5,000	$10,000
Ages 70 to 75	$5,000	–

Beneficiary Designation

You may designate a beneficiary for your Group Term Life Insurance and AD&D Insurance. By designating a beneficiary you ensure that the distribution of your estate goes to the people you want. The Beneficiary Designation/Change Form should be completed when you elect a beneficiary or if you wish to change your beneficiary designation.

If you do not name a beneficiary, payment of any death benefits will be made to your estate.

Group Term Life Insurance Conversion to an Individual Policy

If you are under age 65 and are no longer eligible to participate or if you choose to terminate your benefits under this Plan you have the option to convert your Group Term Life Insurance to an individual policy without providing evidence of medical insurability. A written request, which includes payment of premium, must be received by AFBS within 30 days of the termination of your benefits under this Plan.

Group Term Life Insurance Limitations

Group Term Life Insurance will not be paid if death is a result of either of the following:

- A suicide which occurs within the first two years of this benefit being available or within the first two years of its latest reinstatement;
- A medical condition that has been diagnosed or which is under review or which a prudent person would have sought medical treatment prior to this benefit becoming available and which results in death within the first six months of this benefit being available.

Accidental Death and Dismemberment Schedule of Covered Losses

AD&D Insurance provides payment for losses resulting from accidental bodily injury and caused by violent and external means as follows:

For Loss of:	Percentage of Coverage
Life	100%
For Total and Irrevocable Loss or Use of:	
Both hands at or above the wrist	100%
Both feet at or above the ankle	100%
One hand at or above the wrist and one foot at or above the ankle	100%
Entire sight of both eyes	100%
One hand at or above the wrist and the entire sight of one eye	100%
One foot at or above the ankle and the entire sight of one eye	100%
Speech	100%
One arm at or above the elbow	75%
One leg at or above the knee	75%
Either hand at or above the wrist	66 2/3%
Either foot at or above the ankle	66 2/3%
Sight of either eye	66 2/3%
Thumb and any finger or any two fingers of either hand at or above the metacarpophalangeal joints	33 1/3%
Hearing in both ears	100%
Hearing in one ear	50%
Paraplegia/quadriplegia/hemiplegia	100%

Benefits for loss of use will be paid if the loss is permanent, total and irrevocable and continuous for 12 months.
If you suffer more than one loss in the same accident, AFBS will pay the largest single benefit for which you are eligible.

Accidental Death and Dismemberment Exclusions

AD&D benefits are not payable if the accidental death or loss of use results from any of the following:

- Suicide or any attempted suicide, while sane or insane;
- Intentionally self-inflicted injury, while sane or insane;
- Inhalation of gas while you are the occupant of a car or confined to a car garage;
- Injury sustained while a pilot or member of a crew of any aircraft;
- Any insurrection or war or if you are in the service of the armed forces or any country which is in a state of war (whether or not war is declared);
- Participation in a riot;
- Abuse of medication, drugs, alcohol or other toxic substances, non-compliance with prescribed medical therapy or treatment. Alcohol abuse is defined as having a blood alcohol level in excess of 80 mg per 100 ml of blood;
- Participation in professional sports, bodily contact sports, acrobatic or stunt flying, hang gliding, parachuting, skydiving, parasailing, rock climbing, mountain climbing, bungee jumping, scuba diving or motorized speed contests.

Aggregate Limit of Indemnity

The total limit of AFBS' liability for all AD&D benefits payable under this plan and in respect to injuries sustained in any one accident by all insured persons is two hundred fifty thousand dollars ($250,000). If the total of all benefits payable as a result of any one accident exceeds the Aggregate Limit of Indemnity then the benefit applicable to each injured person will be proportionally reduced to effect a proportionate distribution of the Aggregate Limit of Indemnity.

Contacting Actra Fraternal Benefit Society (AFBS)

AFBS

1000 Yonge Street, Toronto, Ontario M4W 2K2

1.855.934.2355
admin@aeplan.ca

Disclaimer

The policy summary pages are provided for informational purposes only. All terms and conditions with respect to the benefits outlined are governed by the master policy issued by Actra Fraternal Benefit Society (AFBS). In the event of a discrepancy, benefits will be paid according to the terms of the master policy and applicable legislation. The AFBS master policy is issued in Ontario and governed by the laws of that province.

Definitions

Insured Person: Means a Member or, where applicable, their dependant(s) who are insured under the provisions of this policy.

Member: Means a member of a Participating Organization or such other individual as the Policyholder may deem eligible to participate under this policy and who has applied for and been issued a Certificate of Insurance by AFBS.

Participating Organization: Means an organization that meets the Arts & Entertainment Plan eligibility, as established by the Policyholder, and where a Letter of Understanding is on file with the Policyholder.

Changes in the Amount of Insurance

Actra Fraternal Benefit Society (AFBS) retains the right to change, modify or terminate, in whole or in part, any insurance benefit subject to the terms of the Letters of Understanding in place with the Participating Organizations.

Termination of Coverage

An Insured Person's coverage terminates on the earliest of:

a) The date AFBS terminates the policy;

b) The date the Insured Person enters the full-time services of any naval, military or air force;

c) The date the Insured Person dies except when the Insured Person is the Member in which case coverage may continue on request for dependants who were insured at that time;

d) Thirty-one (31) days after the month in which the Member, or dependant(s) (when the Member is deceased) does not make the required premium payment to AFBS;

e) The first of the month following the date from which AFBS receives notification from the Member to terminate coverage.

The Contract

The Group Insurance Policy #22000, the Member's application for coverage (Enrollment Form or electronic application) under the Arts & Entertainment Plan, Letters of Understanding with Participating Organizations, your Certificate of Insurance as issued by AFBS, AFBS' Instrument of Incorporation and its by-laws and all amendments thereof, constitute the entire policy.

Any changes, additions or amendments to the AFBS Instrument of Incorporation or its by-laws made subsequent to November 1, 2011 which is the restatement date of Group Insurance Policy #22000 shall be binding and shall thereafter govern and control this policy in all respects.

All statements in the Member's application for coverage (Enrollment Form or electronic application) shall be deemed representations and not warranties. No statement shall invalidate the policy or be used by AFBS to contest a claim unless it is contained in the application.

Incontestability

Any Certificate of Insurance issued shall be incontestable except for non-payment of premium after it has been in force for two (2) years from its Effective Date of Coverage.

No statement relating to the insurability of any Insured Person may be used in contesting the validity of the insurance for which the statement was made after the insurance has been in force for a period of two (2) years during the Insured Person's lifetime. However, AFBS may contest the validity of insurance for any Insured Person at any time in the event of fraudulent statements. In the absence of fraud, all statements made are deemed to be representations and not warranties.

Payment of Premium

Premiums are due in advance. Where the monthly pre-authorized debit mode has been elected by the Member, each monthly premium withdrawal will be on the 15th of each month or the first business day thereafter.

A grace period of 31 days after the premium date is allowed for the payment of each premium due. During the grace period coverage remains in effect. If any premium remains unpaid at the end of the grace period, coverage will terminate immediately on the expiry of the grace period and as of the last date for which premium has been received.

Premium Rate Change

Premiums are based on the Member's age at the beginning of each Benefit Year. AFBS may change the age band premium rates charged for all insured Members. The insured Member's monthly premium rate will change at the commencement of the next Benefit Year, as stated on the Certificate of Insurance Cover Page, provided the Member has received at least 30 days written notice in advance of the premium rate change.

Notice and Proof of Claim

Written proof of claim for health benefits must be given to AFBS within 90 days of the end of the Benefit Year in which the expense was incurred. However, when an Insured Person's insurance terminates for any reason, written proof of claim must be given to AFBS not later than 30 days following the date of termination of insurance.

AFBS shall have the right to request a medical or dental examination, at its own expense, when and so often as may be reasonable. Payment of any claim will be made only to the Member. Such payment shall fully discharge AFBS to the extent of such payment.

Legal Actions

No action or proceeding against AFBS in respect of claim made under Group Insurance Policy #22000 will be started within 60 days of the date on which initial proof or claim is provided to AFBS. No such action will be taken against AFBS more than one (1) year (or such longer period that is specifically required by law) after the end of the period within which the initial proof of claim is required by AFBS.

Subrogation (Third Party Liability)

In the event that benefits under this policy are payable with respect to an Insured Person and in the further event that such Insured Person has a right to recover damages from any individual or organization, AFBS will be subrogated in the amount of any benefits paid under this policy to the rights of recovery of the Insured Person against any such individual or organization. The Insured Person will reimburse AFBS in the amount of any benefits paid out of the damages recovered. Without limiting the generality of the foregoing, the term damages will include any lump sum or periodic payments received on account of (i) past, present or future loss of income, and (ii) any other benefits, otherwise payable under this policy.

A Member shall be required to notify AFBS immediately if he or his dependant commences an action against a third party which includes a claim for wage loss or for any other benefits, otherwise payable under this policy. The Insured Person's solicitor shall represent the AFBS' subrogated rights unless AFBS provides notice to appoint another solicitor to act on its behalf. AFBS reserves the right to commence an action to pursue the subrogated rights contained herein against the third party, in which event, the Member agrees to fully co-operate with AFBS in pursuing claim against the third party.

The Member shall be required to notify AFBS about any judgements or settlements of claims against a third party in the circumstances indicated above. The Member shall also provide all records, transcripts, reports and information to AFBS that may be reasonably demanded with respect to the calculation or allocation of damages.

If a lump sum payment is made under judgement or settlement for loss of future income or for future periodic or lump sum benefits which would otherwise be payable under this policy, no further benefits will be paid under this policy until such time as the monthly or periodic benefits which would otherwise be payable under this policy equal the amount received in a lump sum.

If a claim for damages against a third party is settled before trial, AFBS shall be reimbursed the amount that reasonably reflects the loss of (i) past, present and future income, and (ii) any other periodic or lump sum benefits, that would otherwise be payable under this policy; notwithstanding the actual terms of the settlement.

Right of Recovery

Whenever payments have been made by AFBS for eligible expenses which in total exceed the maximum amount payable at the time of claim, AFBS shall have the right to recover such payment, to the extent of such excess, from one or more of the following, as determined by AFBS:

a) The Insured Persons;

b) Any other insurance organization; and

c) Any other organization.