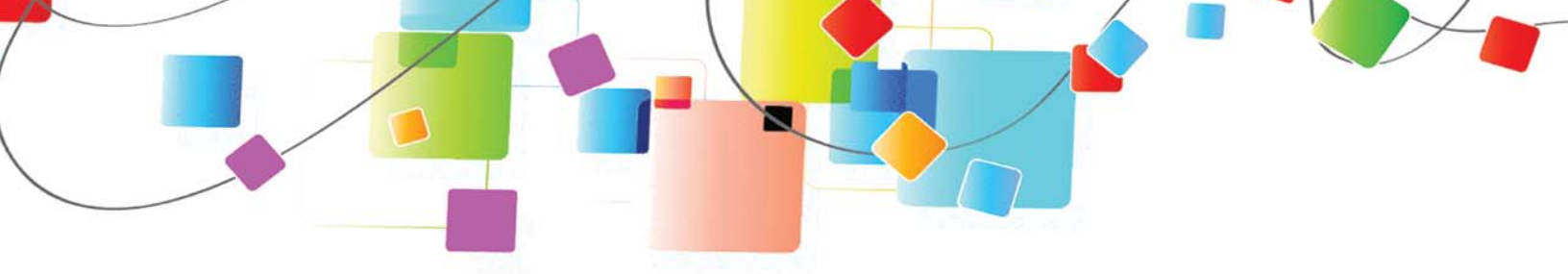




THE  
**ARTS &**  
ENTERTAINMENT PLAN



# DRUG, HEALTH AND DENTAL CARE PROTECTION PROGRAM HANDBOOK



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## IMPORTANT INFORMATION

This booklet outlines the eligible expenses covered under the Arts & Entertainment Plan™. This Plan was developed specifically for the artistic community and membership is limited to the individuals associated with a Participating Organization. When requested by a Participating Organization, its employees may also apply. The Plan is underwritten by Actra Fraternal Benefit Society (AFBS).

Actra Fraternal Benefit Society is a not-for-profit, Member owned, federally incorporated insurance company and financial institution operating for over 35 years. Members of AFBS are primarily members of ACTRA and the Writers Guild of Canada. AFBS is proud to expand its membership across Canada to include professional artists: whether performers, dancers, visual or recording artists.

All terms and conditions with respect to the Arts & Entertainment Plan™ are governed by the master policy, issued by Actra Fraternal Benefit Society. In the event of a discrepancy, benefits will be paid according to the terms of the master policy and applicable legislation.

AFBS retains the right to change, modify or terminate in whole or in part, any insurance benefit contained in the policy.



### ACTRA FRATERNAL BENEFIT SOCIETY (AFBS) IS UNDERWRITING THE PROGRAM...

*...a not-for-profit, Member owned insurance company operating for over 35 years.*


*Members of AFBS are primarily members of ACTRA and the Writers Guild of Canada.*

## PROTECTING YOUR PRIVACY

Protecting plan member confidentiality is of the utmost importance to AFBS. It is fundamental to the way we conduct business. It continues to be our highest priority when dealing with members. AFBS collects personal information about you and your family, as required, to accurately manage and administer the eligible insurance benefits. In turn, AFBS provides member information to ClaimSecure, who provide the on-line claims service for the adjudication and reimbursement of eligible drug and dental expenses. ClaimSecure ensures the highest level of member confidentiality because of the nature of the services they provide as well as their contractual obligations to AFBS.

Any personal information held by AFBS or any other AFBS insurance partner is kept strictly confidential and is only available to you or your representative, as designated by you.

The AFBS Benefits department is committed to resolving any privacy issue with you as quickly as possible. If there is a privacy or confidentiality issue that is not resolved to your satisfaction, please provide written notice to the Privacy Officer at AFBS.



*If you have any questions or issues about the privacy and confidentiality of your personal information, please contact us.*

*AFBS is committed to treating your confidential information with the greatest respect and consideration. Our objective is to provide you with the highest possible level of service.*



## FAST FACTS

- You are eligible if you are associated with a Participating Organization through membership or employment.
- Drug, Health and Dental Care coverage is offered as a package.
- Insurance coverage increases in year 2 and year 3.
- You may choose to pay premiums annually or monthly.
- There is no medical required to join.
- You may insure your eligible dependant(s) for coverage (your spouse and each eligible dependant child under 18 or under 26 if still in school).
- Your eligible dependant(s) have the option to continue coverage in the event of your death.
- Your coverage becomes effective the first day of the month after AFBS approves your Enrolment Form and premium payment.
- Your Benefit Year runs for 12 months from the effective date of your coverage. For example, if your membership began effective November 1, 2011, your Benefit Year would run from November 1, 2011 up to October 31, 2012. The second Benefit Year would run from November 1, 2012 to October 31, 2013.
- Your premium costs are guaranteed for twelve months from the effective date of your coverage.
- You will receive a Claim Card with an AFBS member account number. You will use this card when going to the pharmacy or visiting your dentist.
- Some drug prescriptions and dental claims can be processed immediately from the pharmacy or dental office. This eliminates the need to send a paper claim to AFBS for processing.
- Your pharmacist or dentist will let you know when you need to submit a paper claim form.
- Dental Care treatment that is expected to cost \$500 or more, and other major dental services, will require *pre-authorization* before treatment begins.

# HOW TO ENROL

You can access the **Arts & Entertainment Plan™ Enrolment Form** from the website **[www.artsandentertainmentplan.com](http://www.artsandentertainmentplan.com)**. Alternatively, please contact the Arts & Entertainment Plan™ administrator at AFBS to obtain a copy of the Enrolment Form.

The **Arts & Entertainment Plan™ Enrolment Form** can be completed on-line. You are required to print, sign and date the form before sending it back to AFBS.

Mail, fax or scan and email your completed, signed Enrolment Form to AFBS.

Contact the Arts & Entertainment Plan™ administrator at AFBS if you have any questions about the Enrolment Form or the application process.

*You are eligible if you are associated with a Participating Organization through membership or employment.*

## ARTS & ENTERTAINMENT PLAN ADMINISTRATOR



1000 Yonge Street  
Toronto, Ontario M4W 2K2

Phone:  
416-967-6600  
1-800-387-8897

Fax:  
416-967-4744  
1-888-804-8929

Email:  
[admin@artsandentertainmentplan.com](mailto:admin@artsandentertainmentplan.com)

Enrolment and claim forms may be dropped off at the AFBS Western Office

Suite 320 - 1155 Pender St. W.  
Vancouver, British Columbia V6E 2P4

Phone:  
604-801-6550  
1-866-801-6550

**ACTRA FRATERNAL BENEFIT SOCIETY (AFBS)**  
*...is the underwriter of the Arts & Entertainment Plan™ (visit [www.actrafrat.com](http://www.actrafrat.com) for more information about AFBS).*

# MONTHLY PREMIUM COSTS

- Premiums for Drug, Health and Dental Care can be paid annually or monthly.
- Couple means yourself and one eligible dependant. This can either be a spouse or a dependant child.
- Your premium rate will be based on your age at the beginning of each Benefit Year.

**BENEFIT YEAR:  
12 MONTHS FROM  
YOUR EFFECTIVE DATE  
OF COVERAGE**

## MONTHLY PREMIUM COSTS

AGE	SINGLE	COUPLE	FAMILY
Up to Age 45	\$109.00	\$202.00	\$293.00
46-50	\$119.00	\$221.00	\$317.00
51-55	\$129.00	\$239.00	\$342.00
56-60	\$141.00	\$262.00	\$373.00
61-65	\$134.00	\$249.00	\$349.00
66-70	\$130.00	\$240.00	\$333.00
71-75	\$117.00	\$217.00	\$300.00

*Québec Members under Age 65* – a surcharge of 10% will be added to the premium costs to meet RAMQ requirements (RAMQ is Québec's mandatory provincial prescription drug plan). When a member has personal coverage such as the Arts & Entertainment Plan™, RAMQ requires that prescription drug benefits be provided to both the member and their eligible dependants in accordance with its prescription drug formulary.

## TERMINATION OF COVERAGE IF PREMIUMS ARE NOT PAID

Insurance coverage will lapse when the monthly premium due for that month is still outstanding at the end of the month. Insurance coverage will terminate when premium due has been outstanding for more than 30 days. Coverage then terminates retroactive to the end of the period for which premium has been received.

## IN THE EVENT OF YOUR DEATH

If you die, coverage for each eligible insured dependant will continue and premiums continue to be paid when due. Your estate is encouraged to contact the Arts & Entertainment Plan™ administrator at AFBS as soon as possible so that its records can be updated and any premium adjustment made.



## ELIGIBILITY

- You may apply for insurance coverage if you are under age 71\*, reside in Canada at the time coverage becomes effective and are associated with a Participating Organization through membership or employment. You may also insure your eligible dependants.
- Eligible dependants are members of your family that are eligible for coverage.

*\*Please note: Insured persons must be continuously insured between ages 65 and 70 to extend coverage beyond age 70.*

### SPOUSE

- Your legally married spouse including your common-law spouse who has been publicly represented as being your spouse/partner and has lived with you for 2 or more years (or length of time as required by provincial legislation). Only one spouse can be covered.

### DEPENDANT CHILD

- Each dependant child under age 18 living with you at home and dependant on you for support.
- Each dependant child between 18 and 26 who is attending a recognized college or university on a full-time basis.
- Each dependant child 18 and over who is incapable of earning a living because of a handicap or disability.

[List of Participating Organizations](#)



### DEPENDANT CHILD

*A dependant child includes an unmarried natural child, stepchild or adopted child who is primarily dependent on you for support.*



# ELIGIBILITY

## ADDING OR REMOVING AN ELIGIBLE DEPENDANT

### Adding a Dependant

You may choose to insure your eligible dependants when you complete the **Arts & Entertainment Plan™ Enrolment Form**. **Please note:** *In order to comply with Québec legislation, you must insure your eligible dependants if they do not have private coverage elsewhere.*

If you wish to insure your first dependant or add a new one after your initial Enrolment Form has been approved, complete the **Dependant Information & Over Age Dependant form\***.

AFBS must be notified within 45 days of a “life event” that resulted in your request to add a dependant (for example, birth of a child, marriage). Coverage will then become effective the first of the month following receipt of notification by AFBS and subject to receipt of any applicable premium.

In situations where AFBS is not advised within 45 days of a ‘life event’, a six month waiting period will apply. Coverage in these cases will become effective the first of the month following a six month waiting period from the date of receipt of notification by AFBS and subject to receipt of any applicable premium.

\*Available at [www.artsandentertainmentplan.com](http://www.artsandentertainmentplan.com) under ‘Forms’ or you may request to have a copy sent to you.

### Removing Dependants

If you want to remove a dependant from your coverage, AFBS must be advised immediately. Please complete the **Dependant Information & Over Age Dependant form\***.

If removing a dependant results in a change to “Single Only” or “Couple” coverage, your premium will be adjusted from the first of the month after receipt of your notification. If you have paid annually, you will receive a premium credit from AFBS.



### NEWBORN

*Newborns are eligible for insurance on the later of 15 days of age or the date of discharge from hospital.*

# YOUR PROGRAM

YOUR PROGRAM IS  
MADE UP OF 3 PLANS:

- 1 PRESCRIPTION DRUG CARE
- 2 EXTENDED HEALTH CARE
- 3 DENTAL CARE

Each plan has different reimbursement and maximum levels.

**BENEFIT YEAR:**  
12 MONTHS FROM  
YOUR EFFECTIVE DATE  
OF COVERAGE

## AT-A-GLANCE

### 1 PRESCRIPTION DRUG CARE

**Reimbursement Percentage** 70% of the ingredient cost for each Insured Person

Annual Maximum for Each Insured Person	Year One	Year Two	Year Three
	\$1,000	\$2,000	\$3,000

**AFBS Drug Formulary** The AFBS prescription drug formulary will be used to settle all drug claims.

*Includes a mail order prescription option and pharmacy wellness initiatives.  
Ingredient Costs cover usual and customary costs. They do not include "dispensing fees".*

Maximum increases each year

### 2 EXTENDED HEALTH CARE

**Reimbursement Percentage** 70% for each Insured Person

Annual Maximum for Each Insured Person*	Year One	Year Two	Year Three
	\$7,500*	\$7,500*	\$7,500*

\*Maximum includes benefits paid for Vision/Paramedical Care

### VISION/PARAMEDICAL CARE

**Reimbursement Percentage** 50% for each Insured Person

Annual Maximum for Each Insured Person	Year One	Year Two	Year Three
	\$500	\$500	\$750

Maximum increases in Year Three

# YOUR PROGRAM

## AT-A-GLANCE CONTINUED

### 3 DENTAL CARE

Reimbursement Percentage for Each Insured Person	Year One	Year Two	Year Three
	50%	50%	50%

#### Annual Maximum for Each Insured Person

• <b>Basic Services</b> (cleaning, recall exams)	Year One	Year Two	Year Three
	\$300	\$300	\$500

• <b>Periodontal</b> (gum disease)	Year One	Year Two	Year Three
	\$500	\$500	\$750

• <b>Endodontic</b> (root canal)	Year One	Year Two	Year Three
	\$500	\$500	\$750

• <b>Major Restorative Services</b> (crowns, bridges, dentures)	Year One	Year Two	Year Three
	\$500	\$500	\$750

Maximum increases in Year Three

**AFBS Dental Formulary** The AFBS dental formulary will be used to settle all claims.

## OTHER PROGRAMS



### Home/Tenant/Home Business/Studio\* & Auto Insurance

Through its provider partner, Dale Parizeau Morris Mackenzie, over 3,000 AFBS members have chosen to participate in these programs. To obtain a no obligation quote based on your specific requirements call 1-800-365-3387.

*\*for visual artists*

Additional details about these programs are available at [www.artsandentertainmentplan.com](http://www.artsandentertainmentplan.com) under 'Other Programs'.



### Musicians' Instrument, Equipment & Liability Insurance

Protect your investment in your career. For more information and for answers to your specific questions go to [www.hkmb.com/AEmusicianinsurance](http://www.hkmb.com/AEmusicianinsurance) or call 1-800-563-9441 and ask for the Music Department.

# 1 PRESCRIPTION DRUG CARE

## ELIGIBLE PRESCRIPTION DRUG CARE EXPENSES

A wide variety of prescription drugs are covered under the AFBS managed drug formulary.

Only those drugs prescribed by a Medical Doctor or other health care providers as may be legislated by your provincial government and eligible under the AFBS formulary are covered. This includes prescribed diabetic supplies.

This is a generic drug plan. This means that a pharmacist will dispense the generic equivalent to the brand name drug unless your Medical Doctor has specifically handwritten “no substitutes” on your prescription.

### 1 PRESCRIPTION DRUG CARE

#### Reimbursement Percentage

70% of the ingredient cost for each Insured Person

#### Annual Maximum for Each Insured Person

Year One	Year Two	Year Three
\$1,000	\$2,000	\$3,000

#### AFBS Drug Formulary

The AFBS prescription drug formulary will be used to settle all drug claims.

Maximum increases each year

*Includes a mail order prescription option and pharmacy wellness initiatives.*

**Ingredient Costs** cover usual and customary costs. They do not include “dispensing fees”.

The cost of prescription drugs is comprised of two components: the ingredient cost and the dispensing fee. The AFBS managed drug formulary reimburses 70% of the usual and customary ingredient cost of covered drugs only. Dispensing fees may vary by pharmacy and also by the type of prescription being dispensed. You are encouraged to speak to your pharmacist about their dispensing fee policies.

*Some pharmacies may charge above the usual and customary costs. When this occurs, your costs may be in excess of those covered by the plan. Official receipts may be submitted to the plan with a written request for review.*



# 1 PRESCRIPTION DRUG CARE

## SPECIAL AUTHORIZATION

A broad range of prescription drugs are covered under the AFBS formulary, however, not all prescription drugs are covered. Also, certain drugs or categories of drugs may require a request for *Special Authorization* or coordination with your provincial drug plan. Typically, expensive new drugs providing minimal or no increased therapeutic value would not be added to the formulary.

*Special Authorization* may also be required in situations where the patient has not responded to first line therapies or where the drug may have potential for widespread use outside of approved use. From time to time new drugs are added to the **Special Authorization Drug List**.

### Special Authorization Process

If you are prescribed a prescription drug which requires *Special Authorization*, or discover at the pharmacy that your prescription drug requires *Special Authorization*, please follow the **Steps to Obtain Special Drug Authorization**, as appropriate.

The *Special Authorization* process includes the completion of a brief questionnaire by your Medical Doctor outlining the medical justification for the prescribed medication. The questionnaire is reviewed by the clinical pharmacists at ClaimSecure who have been contracted by AFBS to provide this service and who follow accepted medical and pharmacological protocols. Their review is done on a completely confidential basis.

You will be responsible for any costs your Medical Doctor may charge for the completion of the **Special Authorization form**. A generic **Special Authorization form** is included in the 'Forms' section of the Arts & Entertainment Plan™ website or by contacting the Arts & Entertainment Plan™ administrator at AFBS.

**IMPORTANT:** The **Special Authorization Drug List** is updated regularly, with new prescription drugs/medications added; criteria updated and, on occasion, drugs removed from *Special Authorization*. This list is current as at the date noted. Every attempt has been made to ensure the accuracy of the information provided however if there are discrepancies the medical and pharmacological protocols in place at ClaimSecure will apply. ClaimSecure has been contracted by AFBS to provide prescription drug formulary management, including the *Special Authorization* process.

## PRESCRIPTION DRUG CARE EXPENSES THAT ARE NOT ELIGIBLE

- 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).



### CLAIMSECURE

*Provides on-line claims adjudication and reimbursement of eligible drug expenses.*



# 1 PRESCRIPTION DRUG CARE

## PRESCRIPTION DRUG CARE EXPENSES THAT ARE NOT ELIGIBLE (CONTINUED)

- 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 and Welfare 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 and certain non-oral hormonal contraceptives.
- More than the customary supply of drugs prescribed by a physician or dentist or a 34 day supply (100 day supply for maintenance drugs), whichever is less.

## SPECIAL NOTE TO SENIOR MEMBERS

### Provincial Government Programs

At the present time, all provincial governments provide a prescription drug plan for seniors. Before turning 65, all senior members are encouraged to apply to their provincial plan for coverage.

A few provinces have instituted financial means tests before payment will be provided under the provincial plans. If you are denied access to the provincial drug plan, it is crucial that you advise the Arts & Entertainment Plan™ administrator at AFBS immediately. Benefits may continue under the Arts & Entertainment Plan™.

If you are a senior member, the cost of prescription drugs is initially paid by your government program. Any eligible out-of-pocket amounts which are not paid by your provincial plan may be reimbursed through the Arts & Entertainment Plan™.

If you are a senior, we encourage you to work with your Medical Doctor who will be familiar with your province's prescription drug program. The provincial plans also have special requirements and programs. You and your Medical Doctor need to apply to these programs first (for example Exception Drug Application, Limited Use or Cancer Care Program). If a prescription drug is not covered by the province, you and your Medical Doctor may make a special request through the *Special Authorization* process, to have the costs paid through the Arts & Entertainment Plan™.



### FOR MEMBERS OVER AGE 65 WHERE A PROVINCIAL SENIORS' DRUG PROGRAM IS AVAILABLE

*AFBS assumes a second payor position after any eligible reimbursement has been made by the provincial drug plan.*



## 2 EXTENDED HEALTH CARE

### PROVINCIAL HEALTH CARE PLAN

You receive basic health care from your provincial plan within Canada. The costs of standard hospital ward accommodation, Medical Doctors' fees and some other services are covered by your provincial plan.

Extended Health Care coverage provided by the Arts & Entertainment Plan™ is intended to supplement, not replace, your provincial plan.

For your own insurance protection, please ensure that your provincial health care coverage is always in effect.

### When You Are Traveling or Residing Temporarily Outside Your Province of Residence

AFBS does not provide hospital or medical coverage, including Medical Doctors' fees, for insured members who are traveling or residing temporarily outside their province of residence.

Please ensure that you have purchased or have appropriate hospital and medical coverage for yourself and your family if you plan to be outside of your province of residence.

### 2 EXTENDED HEALTH CARE

<b>Reimbursement Percentage</b>	70% for each Insured Person		
<b>Annual Maximum for Each Insured Person*</b>	<b>Year One</b>	<b>Year Two</b>	<b>Year Three</b>
	\$7,500*	\$7,500*	\$7,500*

*\*Maximum includes benefits paid for Vision/Paramedical Care*

## 2 EXTENDED HEALTH CARE

### EXTENDED HEALTH CARE ELIGIBLE EXPENSES

Your Arts & Entertainment Plan™ covers the following medical supplies and services:

#### ELIGIBLE EXPENSES

Benefit	Coverage Limits for Each Insured Person Benefit Year – As indicated on your Certificate of Insurance
<b>Transportation to Hospital by Ground Ambulance</b>	Covered when not paid by the provincial plan.
<b>Air Ambulance</b>	Maximum of \$4,000 each Benefit Year when not paid by the provincial plan. Only payable for flights originating and terminating in Canada.
* <b>Private Duty Nursing</b>	Maximum of \$2,500 each Benefit Year.
<b>Hospitalization</b>	Reimbursed at 70% for the first 5 days and 100% thereafter each Benefit Year. Semi-private room for acute illness and rehabilitation only. Rehabilitation is covered only when followed immediately after a minimum of three days of acute care and for a maximum of 6 weeks. Where rehabilitation is expected to exceed 6 weeks, prior approval must be obtained from AFBS. Rehabilitation excludes the treatment of addiction.
* <b>Home Care Following Hospitalization</b>	Maximum of \$30 each day for a maximum of 30 days each Benefit Year.
* <b>Wigs</b>	Lifetime maximum of \$1,000 only for cancer patients undergoing chemotherapy.
* <b>Artificial Limbs and Eyes</b>	Maximum of \$5,000 every 5 Benefit Years, or every 3 years of continuous coverage for a dependant child under 18 years of age.
* <b>Hearing Aids</b>	Maximum of \$500 per ear every 4 Benefit Years, or every 2 Benefit Years for a dependant child under age 18.
* <b>Physiotherapist</b>	Maximum of \$750 each Benefit Year.
* <b>Audiologist, Speech Therapist</b>	Combined maximum of \$750 each Benefit Year.
<b>Eye Examinations</b>	Maximum \$80 every two Benefit Years.
* <b>Medical Equipment</b> • Hospital Bed • Wheelchair • Oxygen Set	Rental or purchase to a lifetime maximum of \$1,500. Rental or purchase to a lifetime maximum of \$1,000. Rental or purchase.
<b>Accidental Dental</b>	Reimbursed at 70% of dental expenses.

Where coverage is available through the Province, the AFBS Program is secondary to any coverage/ assistance provided by the Province as appropriate. Supporting documentation may be required.

Eligible expenses must be considered medically necessary for the treatment of an illness or injury and recommended by a Medical Doctor.

\* This image 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.

## 2 EXTENDED HEALTH CARE

### Assistive Devices

The purchase or rental of assistive devices, mobility aids and medical equipment is limited to the terms specified below. Where no maximum is stated, the Program reimburses 70% up to the usual and customary cost of these items.

Benefit	Coverage Limits for Each Insured Person <i>Benefit Year – As indicated on your Certificate of Insurance</i>
* Walker	Covered up to the usual customary charges.
Urethral Catheters	Covered up to the usual customary charges.
* Casts, Splints, Walking Cane, Crutches	Covered up to the usual customary charges.
* Cervical Collar	Covered up to the usual customary charges.
Tracheostoma Tubes	Covered up to the usual customary charges.
Colostomy and Ostomy Supplies Where Surgical Stoma Exists	Covered up to the usual customary charges.
* Abdominal, Back or Knee Brace	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 each Benefit Year.
* Devices and Medical Aids Necessitated After Surgery	Covered up to the usual customary charges.
* Tens Machine (transcutaneous nerve stimulator for chronic pain)	Lifetime maximum of \$500.
Support Hose and Compression Stockings	Maximum 4 pairs each Benefit Year.
Surgical Brassieres	Maximum 2 each Benefit Year.
Blood Glucose Monitoring Machine	Maximum of one each 5 years.
* Insulin Pump	Lifetime maximum of \$1,000.
External Breast Prosthesis (when required as a result of a total or radical mastectomy)	Maximum of one each Benefit Year.
Stump Socks	Maximum 4 pairs each Benefit Year.

\* This image 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, AFBS may request a written medical recommendation with the initial claim submission and at its discretion.

# 2 EXTENDED HEALTH CARE

## 2 VISION/PARAMEDICAL CARE

<b>Reimbursement Percentage</b>	50% for each Insured Person		
<b>Annual Maximum for Each Insured Person</b>	<b>Year One</b>	<b>Year Two</b>	<b>Year Three</b>
	\$500	\$500	\$750
<b>Annual Maximum of Extended Health Care Combined with Vision/Paramedical Care Expenses</b>	\$7,500		

Maximum increases in Year Three

## ELIGIBLE EXPENSES

<b>Benefit</b>	<b>Coverage Limits for Each Insured Person</b> <i>Benefit Year – As indicated on your Certificate of Insurance</i>
<b>Vision Care</b>	\$250 every two Benefit Years with a \$125 maximum reimbursement limit in the first year your insurance is in place.  For example, if you claim \$100 in the 1st Benefit Year, you are eligible to claim \$150 in the 2nd Benefit Year. In the 3rd Benefit Year, you would be eligible to claim up to the \$250 maximum.
<b>Registered Psychologist, Chiropractor, Naturopath, Homeopath, Chiroprapist, Podiatrist, Osteopath</b>	Maximum of \$35 each visit.
* <b>Registered Massage Therapist, Traditional Chinese Medicine, Acupuncturist, Dietician</b>	Maximum of \$35 each visit.

\* This image 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.

### NATUROPATH

Treatments that avoid drugs, surgery and utilize the use of natural agents such as herbs.

### CHIROPODIST/ PODIATRIST

Medical care and treatment of the human foot.

### OSTEOPATH

Medical care and treatment of bone disease.



## 2 EXTENDED HEALTH CARE

### EXTENDED HEALTH CARE EXPENSES THAT ARE NOT ELIGIBLE

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 bills for hospital or Medical Doctors' fees.
- Surgeries performed privately and outside of provincial health care plans.

# 3 DENTAL CARE

The plan reimbursement is based on two components:

1. Dental services covered under the AFBS dental formulary.
2. Current Dental Association Fee Guide in the province where you reside.

If dental services are provided outside Canada they will be reimbursed based on the current Ontario Dental Association Fee Guide.

The AFBS dental formulary has been designed to cover usual and customary dental procedures, as determined by AFBS, as well as to ensure a high level of Dental Care. Not all dental procedures are available under the AFBS dental formulary. There are limits on the frequency of some of the services and the amount that can be reimbursed.

We encourage you to share your coverage information with your dentist.

## 3 DENTAL CARE

Reimbursement Percentage for Each Insured Person	Year One	Year Two	Year Three
	50%	50%	50%

### Annual Maximum for Each Insured Person

• <b>Basic Services</b> <i>(cleaning, recall exams)</i>	Year One	Year Two	Year Three
	\$300	\$300	\$500

• <b>Periodontal</b> <i>(gum disease)</i>	Year One	Year Two	Year Three
	\$500	\$500	\$750

- **Endodontic**  
*(root canal)*
- **Major Restorative Services**  
*(crowns, bridges, dentures)*

**AFBS Dental Formulary** The AFBS dental formulary will be used to settle all claims.

Maximum increases in Year Three



## 3 DENTAL CARE

### SOME EXPENSES REQUIRE PRIOR PRE-AUTHORIZATION

If your dentist recommends dental work that will cost more than \$500 or includes procedures such as crowns, bridgework, veneers, implants, onlays or inlays, you must have your expense *pre-authorized* by AFBS. Your dentist must provide AFBS with specific information, including x-rays, study moulds or casts.

*Pre-authorization* is not required 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-authorization* is not necessary for a crown if a root canal has been performed on the tooth. The dentist needs to indicate this on the claim form.

Through the *pre-authorization* process, you will have confirmation of the amount eligible for reimbursement through the Program before treatment starts.



#### PRE-AUTHORIZATION

...is required for treatment that will cost \$500 or more.

### DENTAL INJURY/ACCIDENT

If you require Dental Care as a result of an accident, you will be insured for any expenses not paid by your provincial health care plan up to the available annual maximum. Payment will be made under the Extended Health Care plan and will not affect your Dental Care annual maximums.\*

*\*AFBS may require supporting documentation as deemed appropriate.*



#### DENTAL CARE DUE TO AN ACCIDENT

...means the treatment resulting from a breakage of a tooth or teeth by a direct accidental blow to the mouth and not by an object placed in the mouth, deterioration of the teeth or by any other cause.

# 3 DENTAL CARE

## DENTAL CARE ELIGIBLE EXPENSES

Where no maximum is stated, the Program reimburses 50% up to the usual and customary cost of these items:

### ELIGIBLE EXPENSES – BASIC SERVICES

Procedure and Service Classification	Coverage Limits for Each Insured Person <i>Benefit Year – As indicated on your Certificate of Insurance</i>
<b>Complete examination and full series of x-rays or panoramic films</b>	Once every five Benefit Years or if a new dentist is involved in the Insured Person's Dental Care.
<b>Recall examination by a dentist</b>	Once every nine months.
<b>Topical application of any anti-carcinogenic agent (e.g. stannous fluoride) or polishing of teeth</b>	Once every nine months.
<b>Routine diagnostic and laboratory procedures</b>	Laboratory fees are limited to a maximum of 50% of the total cost of the dental procedures.
<b>Prophylaxis, including deep scaling</b>	10 units each Benefit Year. <i>Pre-authorization</i> for any additional units is required from the AFBS dental consultant.
<b>Bitewing x-rays</b>	Once each Benefit Year.
<b>Oral hygiene instruction</b>	Once each lifetime.
<b>Fillings (amalgam, silicate, acrylic and composite), retentive pins and pit and fissure sealants</b>	Covered up to the usual customary charges.
<b>Space maintainers</b>	Covered up to the usual customary charges.

**BENEFIT YEAR:  
12 MONTHS  
FROM YOUR  
EFFECTIVE  
DATE OF  
COVERAGE**

**50% up to plan limits.**

# 3 DENTAL CARE

## DENTAL CARE ELIGIBLE EXPENSES (CONTINUED)

### ELIGIBLE EXPENSES – PERIODONTAL, ENDODONTIC AND MAJOR RESTORATIVE SERVICES

**Procedure and Service Classification**

**Coverage Limits for Each Insured Person**  
*Benefit Year – As indicated on your Certificate of Insurance*

<b>Periodontal – Treatment of diseases of the gums and other supporting tissue of the teeth (excluding splinting), including surgery and post surgical treatment and appliances</b>	Periodontal appliances are limited to once every 24 months per arch.
<b>Root canal therapy, root amputation, apexification (end of the root) and periapical services (surrounding bottom of the root of a tooth)</b>	Covered up to the usual customary charges.
<b>Oral surgical procedures including the removal of teeth</b>	Covered up to the usual customary charges.
<b>General anesthesia and x-rays</b>	X-rays are limited to three each Benefit Year. General anesthetic is paid in conjunction with eligible oral and surgical procedures.
<b>Crowns, inlays and onlays</b>	Only when the function is impaired due to cuspal or incisal angle damage caused by trauma or decay.
<b>Replacements of crowns, inlays and onlays</b>	Once every five Benefit Years.
<b>Implants</b>	Reimbursement may be limited to that of the generally accepted alternative. Costs may not be applied across Benefit Years.
<b>Initial provision for fixed bridgework</b>	Covered up to the usual customary charges.
<b>Replacement of fixed bridgework or additional teeth to bridgework</b>	When replacement or addition is due to one of the following: <ol style="list-style-type: none"> <li>1. A natural tooth is extracted and the existing appliance cannot be made serviceable.</li> <li>2. The existing appliance is at least five years old and cannot be made serviceable.</li> <li>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.</li> </ol>

**BENEFIT YEAR:  
12 MONTHS  
FROM YOUR  
EFFECTIVE  
DATE OF  
COVERAGE**

*50% up to plan limits.*

# 3 DENTAL CARE

## DENTAL CARE ELIGIBLE EXPENSES (CONTINUED)

### ELIGIBLE EXPENSES – PERIODONTAL, ENDODONTIC AND MAJOR RESTORATIVE SERVICES (CONTINUED)

Procedure and Service Classification	Coverage Limits for Each Insured Person <i>Benefit Year – As indicated on your Certificate of Insurance</i>
<b>Initial provision of full or partially removable dentures</b>	Covered up to the usual customary charges.
<b>Repair or re-cementing of crowns, onlays, inlays, bridgework and dentures, or relining and rebasing of dentures</b>	Covered up to the usual customary charges.
<b>Replacement of removable dentures</b>	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.
<b>Addition of teeth to an existing partial denture or fixed bridgework previously removed</b>	When required to replace one or more teeth.
<b>Procedures involving the use of gold</b>	Only when there is no alternative consistent with generally accepted dental practice.

**BENEFIT YEAR:  
12 MONTHS  
FROM YOUR  
EFFECTIVE  
DATE OF  
COVERAGE**

**50% up to plan limits.**

Limitations are generally accepted guidelines, but where a situation is warranted, a review by the AFBS dental consultant may be requested.

Claims for some procedures, including full series of x-rays and panoramic films and major restorative work cannot be processed electronically. When claims are not processed electronically a standard dental claim form must be submitted to AFBS.



## 3 DENTAL CARE

### DENTAL CARE EXPENSES THAT ARE NOT ELIGIBLE

- 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 Program.
- 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-authorization*.




# MAKING A CLAIM

All claim forms and claims procedures are found on the Arts & Entertainment Plan™ website or by contacting the Arts & Entertainment Plan™ administrator at AFBS.


## CLAIM CARD AND CLAIM CARD NUMBER

Electronic submission of Prescription Drug Care and Dental Care expenses will be possible in many situations. Within one month of your enrolment into the Program, you will receive a Claim Card that you and your eligible dependants will use when claiming benefits.

You will be assigned a unique AFBS member account number. It is important that your pharmacist and dentist have this new Claim Card member account number information. Without it, they will not be able to process an eligible claim electronically.




The **Extended Health Care** and **Prescription Drug** claim forms are available at [www.artsandentertainmentplan.com](http://www.artsandentertainmentplan.com) under 'Forms'.



Your pharmacist or dentist will let you know when a paper claim form must be completed.

## CLAIMS SUBMISSION



Claims for a previous Benefit Year must be submitted within 90 days of the close of the Benefit Year indicated on your Certificate of Insurance to remain eligible for payment.



# MAKING A CLAIM

## PRESCRIPTION DRUG CARE AND DENTAL CARE – TRANSMITTING CLAIMS ELECTRONICALLY

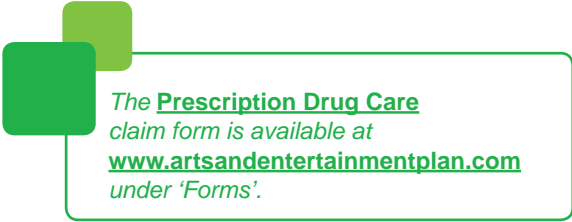
In most cases, your pharmacist will transmit your prescription claim electronically. Similarly, many dental offices will also file claims electronically. AFBS works with ClaimSecure to provide members and their covered dependants with pay-direct claims payments for Prescription Drug and Dental Care coverage. Since these claims are processed through the ClaimSecure network, the pharmacy and dental office require the information contained on your new AFBS Claim Card to process your claim.

### **Electronic Submission is Not Possible for All Prescription Drug and Dental Claims**

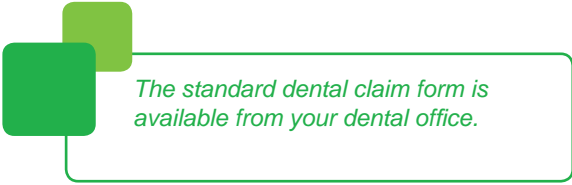
Electronic submission is not possible for all prescription and dental claims. For example, compound prescriptions and dental claims for procedures, including certain x-rays and major restorative work cannot be submitted electronically.

When electronic transmission is not possible for a prescription drug expense, please send the original official receipt from the pharmacy with a completed **Prescription Drug Care claim form** to AFBS. If your dental office cannot submit your claim electronically, you must send AFBS an original standard dental claim form which must be completed by your dentist.

If AFBS is the second payor, please include the receipt of claim settlement information, often called an Explanation of Benefits (EOB), from the other insurance company along with copies of the official receipt from the pharmacy or a completed standard dental claim form to AFBS.



The **Prescription Drug Care** claim form is available at [www.artsandentertainmentplan.com](http://www.artsandentertainmentplan.com) under 'Forms'.



The standard dental claim form is available from your dental office.



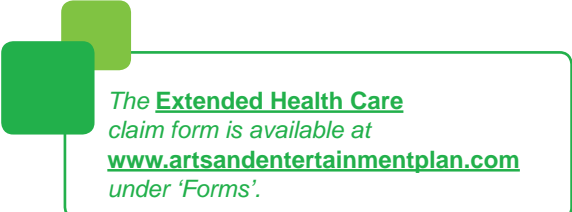
# MAKING A CLAIM

## EXTENDED HEALTH CARE CLAIMS

An **Extended Health Care claim form** is available on the website under "Forms". You need to complete, sign and date this form and return it to AFBS.

To claim expenses when AFBS is the first or only insurance company provider, send your original receipts along with your completed and signed claim form directly to AFBS. Photocopies cannot be accepted. When submitting original receipts, please block any confidential information such as a credit card number.

If AFBS is the second payor, please include the receipt of claim settlement information, often called an Explanation of Benefits (EOB), from the other insurance company along with your completed and signed **Extended Health Care claim form** and copies of your receipts.



The **Extended Health Care claim form** is available at [www.artsandentertainmentplan.com](http://www.artsandentertainmentplan.com) under 'Forms'.



**Extended Health Care claim form** must be completed, signed and submitted to AFBS.



## COORDINATION OF BENEFITS WITH OTHER INSURANCE PROGRAMS

### STEP 1

If you or your spouse/partner has coverage with another insurance company, you should send the claims to that insurer for payment. However, if you are a dependant under your spouse/partner's coverage, your claim must be sent to AFBS first. Usually, claims for insured dependant children must be submitted to the plan of the parent whose birth day and month falls first within the calendar year. When administering coordination of benefits AFBS follows the guidelines established by the Canadian Life and Health Insurance Association (CLHIA).

### STEP 2

After settling a claim with the primary insurer, any portion not paid by the other insurance company will be reported on the Explanation of Benefits (EOB) statement. Submit this explanation to AFBS along with a completed claim form and copies of your original receipts.

### STEP 3

AFBS will adjudicate the remaining amount that was not paid by the primary insurer. You will be reimbursed up to your benefit level or 100% of the eligible health or dental expenses unpaid by the other insurer.

When you are coordinating claims between insurance companies, you will be required to provide copies of your receipts to the second insurer in order to be reimbursed by them.

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