EXTENDED HEALTH CARE PLAN

ARTA BENEFIT PLANS

BUILD YOUR OWN PLANS

Benefit Plan Coverage effective
November 1, 2023

Revision: May 1, 2024

ARTA Rx

ARTA Rx + TRAVEL

Contents

ARTA ARTARx Extended Health Care Summary

Plan Provision	ARTARx and ARTARx+Travel Plans
Coverage Level	90%, unless otherwise noted
Deductible	None
Annual Maximum Excluding Travel	$10,000
Prescription Drugs	100% coverage for all eligible medications under the plan dispensed by ARTARx Pharmacy 80% coverage for acute need medications not dispensed by ARTARx Pharmacy Up to 50% coverage for Chronic Care Medications not dispensed by ARTARx Pharmacy
Annual Maximum	$2,500
Lifestyle Drugs	80% coverage for hair loss, erectile dysfunction, and weight-loss medications
Vision Care	$600/24 months
Paramedical Practitioners	$1,400 combined per year
Hospital	100%; semi-private or private accommodation
Accidental Dental	$5,000/year
Ambulance	Covered
Hearing Aids	$1,500/36 months
Orthopedic Shoes	$750/3 years
Orthotics	$300/3 years
Wheelchairs and Mobility Scooters	Covered
Walkers	$120/year
Medical Aids and Appliances	Trusses, splints, braces, canes, casts, knee walkers, artificial limbs, or breast prosthesis. Other medical aids covered – see applicable section of this booklet.
Diabetic Supplies	100% to $2,000/year
Insulin Pump	$5,000/4 years
Private Duty Nursing	$3,000/year
Geriatric Chair	$1,000 lifetime
ARTACares	Medical Second Opinion, Eldercare, Chronic Disease Support, and Health Care System Navigation services
Member Assistance Plan	Up to 5 hours per year
Health Education Program	$100/year when prescribed by an appropriate health care practitioner
Virtual Physician Services	Included
Emergency Travel Insurance Included in ARTARx+Travel plan	100% coverage for sudden and unforeseen eligible emergency medical travel expenses
Lifetime Maximum	$5,000,000
Base Travel Maximum Trip Duration	92 days per trip; multiple trips covered
Supplemental Travel Maximum Single Trip Duration	120 days (212 days total, combined with Base Travel); additional premium applies – contact Plan Administrator to enroll
Trip Cancellation/ Interruption/Delay Insurance	$10,000 per trip

General Information

About this Booklet

The information contained in this booklet is important to you. It provides the information you need about the ARTARx and ARTARx+Travel Extended Health Care benefits available through the Alberta Retired Teachers' Association (ARTA) Benefit Plans.

Your Extended Health Care coverage may be modified after the effective date of this booklet. You will receive notification of changes to this plan via the website www.arta.net.

If you have any questions about the information in this booklet, or you need additional information about your Extended Health Care benefits, please contact ARTA's Plan Administrator. A summary of Providers and Contact Information is available on the last page of this booklet.

This booklet also serves as the Plan Text for the administration of the ARTARx and ARTARx+Travel Extended Health Care Plans.

ARTA self-insures all non-emergent inside Canada Extended Health Care benefits. This means ARTA has sole legal and financial liability for the inside Canada Extended Health Care claims. Emergency Travel coverage is provided to participating ARTA members on a fully insured basis by the Emergency Travel Insurance provider.

Member Eligibility

To be eligible for the benefits described in this booklet, you must be:

- a permanent resident of Alberta;
- covered for any provincial, territorial, or public health care plans for which you are eligible; and
- an ARTA member in good standing.

ARTA membership eligibility details are available on the ARTA website www.arta.net.

You become eligible to be covered under this Plan on the date you become a Member or Affiliate Member of the Alberta Retired Teachers' Association; and

a) you confirm you currently have similar group benefits coverage under an employer-sponsored group benefits plan; or

b) your coverage under an employer-sponsored group benefits plan terminates (either your own plan, or your spouse's plan under which you were covered as an eligible dependant); or

c) your coverage under an employer-sponsored group benefits plan, other than those plans mentioned in b) above, terminates.

If you are applying for coverage under the ARTARx+Travel Plan while you have similar coverage in place under an employer-sponsored group benefits plan (either your own plan or your spouse's plan under which you are covered), you may apply for coverage at any time following the date you become a Member or Affiliate Member of the Alberta Retired Teachers' Association. Your coverage shall become effective on the date the Plan Administrator approves your completed application.

If you are applying for coverage under the ARTARx+Travel Plan following termination of coverage under an employer-sponsored group benefits plan, your application for coverage must be received by ARTA on, before, or within 60 days of your employer-sponsored group benefits plan coverage termination date (the Eligibility Period) in order to qualify for coverage without requiring submission of medical evidence of insurability. Your

coverage shall become effective on the date your prior coverage terminated.

If you do not apply within the Eligibility Period, you may enrol as a Late Applicant and may be required to submit medical evidence of insurability to be approved for coverage. Your coverage shall become effective on the date the Plan Administrator approves your completed application and medical evidence of insurability.

If you have elected coverage under the ARTARx plan and wish to enrol in the ARTARx+Travel plan following 60 days of the Eligibility Period as determined above, you may enrol as a Late Applicant and will be required to submit medical evidence of insurability to be approved for coverage.

You must be located within Alberta for the inside Canada coverage to be in effect. If you are away from Alberta on your effective date of coverage as determined above, coverage will not be effective until the date you return to Alberta.

This Plan is Contributory, meaning you pay all of the applicable monthly benefits premiums.

Your ARTA Benefit Plans Identification Card indicates the benefits for which you are eligible, your applicable coverage level, and serves as your proof of coverage.

A person may only be covered once under this Plan.

Dependant Eligibility

Your dependants become eligible for coverage on the date you become eligible, the date they are approved by the Plan Administrator if a late applicant, or the date they first become your dependant, whichever is later. ARTA needs to be notified

within 31 days of your dependant becoming eligible otherwise they will be considered a late applicant.

Evidence of Insurability is required if your dependant is a late applicant. If evidence of insurability is required and/or your dependant is confined to a hospital, the effective date of coverage shall be the first date your dependant is not confined to a hospital, or the date coverage is approved by the Plan Administrator.

Confinement in a hospital shall not postpone the effective date for a child born while your dependants are insured, or a mentally or physically handicapped child of any age.

Extended Coverage for Dependants

Coverage for your dependants if you die:

Coverage for your eligible surviving spouse shall continue following your death, provided premiums continue to be paid, until the date the policy terminates, or your spouse's coverage otherwise would terminate under the other provisions of the policy. Eligible dependant children may also continue to be covered under your surviving spouse's plan.

Coverage upon Remarriage of your surviving spouse:

If you die, upon Remarriage of your surviving spouse, the new spouse and any dependant children acquired resulting from the Remarriage will be eligible for coverage, subject to the Eligibility provisions for dependants, as long as ARTA is informed of the Remarriage within 30 days of the date of the Remarriage.

EHC Coverage Level Minimum Participation Requirements

If you choose to participate in either the ARTARx or ARTARx+Travel plans but wish to change your coverage, you may terminate your coverage or transition your coverage to another

ARTA-sponsored Extended Health Care plan for which you are eligible.

You may change from the ARTARx+Travel plan to the ARTARx plan at any time, recognizing that if you want to revert to the ARTARx+Travel plan at a later date you will be subject to the medical evidence of insurability guidelines included in the Member Eligibility section of this booklet.

Premium Payments

The premiums applicable to this plan are payable on each premium due date via direct bank account withdrawal, or if grandfathered to do so, via pension deduction. Premiums are paid by regular, interest-free monthly deductions as authorized on your application for benefits.

To request a cancellation and/or refund of premium, all requests must be made in writing to the Plan Administrator. Retroactive refund of premiums is limited to 12 months.

Premiums are not charged, and refunds are not allowed, for partial months, except for the Supplemental Emergency Travel premiums.

A refund and/or adjustment of premium is available under the Supplemental Emergency Travel Plan providing no Emergency Medical or Trip Cancellation, Interruption & Delay insurance claims have been made or are pending:

a) in the event of an early return from a trip, proof of departure and early return must be provided in the form of a stamped passport, airline ticket or boarding pass, credit card receipt, border crossing slip, or any signed and dated document that proves you have returned to your province or territory of residence; and

b) in the event that a situation covered under this insurance occurs which necessitates Trip Cancellation before your day of departure, you may request a refund of premium or alternatively, a change in your Supplemental Plan trip coverage dates.

In the event of an early return from a trip, no downgrade in coverage or refund of premium is permitted under the Supplemental Emergency Travel Plan if a claim has been incurred during the supplemental portion of your trip.

Grace Period

After your initial premium payment, each subsequent payment must be received within thirty-one (31) days after the premium due date, otherwise your coverage will be automatically terminated at the end of the grace period.

Premium payment is paid via direct bank account withdrawal by the Plan Administrator, or if grandfathered, via pension deduction. If the Plan Administrator is unable to withdraw your monthly premium payment from your bank account, the Grace Period applies.

Reinstatement of Coverage for Non-Payment

If your coverage is terminated for non-payment of premium, your coverage can be reinstated providing the outstanding and current premium owing is paid and provided the outstanding and current premium owing is no more than three (3) consecutive months.

If your coverage has been terminated for non-payment of premium, and the outstanding and current premium owing exceeds three (3) consecutive months, the Plan Administrator will not entertain an application for the reinstatement of coverage until a period of 24 months has elapsed after the date of termination. Any person who was previously covered under the

Plan and wishes to make an application after the 24-month waiting period will be considered a Late Applicant.

Termination of your Coverage

Your coverage under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Plan Administrator or Policyholder;
b) the date your written request to terminate coverage is received by ARTA or the Plan Administrator;
c) the date you no longer make premium payments, following the 31-day grace period;
d) the date you are no longer eligible for coverage;
e) the date you enter the Armed Forces of any country, state, or international organization on a full-time basis; or
f) the date you die.

If you terminate coverage under this Plan, you may not re-apply for coverage for a period of 12 months following termination without written consent from ARTA.

Termination of your Dependant's Coverage

Coverage for your dependant(s) under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Plan Administrator or the Policyholder;
b) the date your written request to terminate dependant coverage is received by ARTA or the Plan Administrator;
c) the date of termination of your coverage, excluding continuation of coverage for your surviving spouse (see section Extended Coverage for Your Dependants);
d) the date you no longer make premium payments, following the 31-day grace period;
e) the date the dependant is no longer eligible for coverage;
f) the date coverage for dependants is terminated; or

g) the date your dependant enters the Armed Forces of any country, state, or international organization on a full-time basis.

Incontestability

No statement made by you in your application for coverage, except for fraudulent statements and omissions, shall be used to contest a claim after your coverage has been in force for two (2) years following your original effective date.

Applicable Law

Any provision of this policy which is in conflict with any federal, provincial or territorial law of your place of residence is amended to comply with the minimum requirements of that law. All other provisions shall remain in full force and effect.

Limitation of Liability

Neither the Plan Administrator nor the Policyholder is responsible for the availability, quality or results of any medical treatment or transportation, or the failure of a Covered Person to obtain medical treatment.

Accessing Your Records

You may obtain copies of the following documents:

- Your enrolment form or application for coverage;
- Any written statements or other records, not otherwise part of the application, which you provided to the Plan Administrator as evidence of insurability.

All requests for copies of documents should be directed to the Plan Administrator.

Privacy Statement

The Federal, Provincial and Territorial Governments enacted legislation to protect the personal information of Canadians. This statement informs you of the steps taken to comply with the legislation. The Plan Administrator, the Policyholder, Emergency Travel Insurance Provider, the Emergency Travel Assistance

Provider, and/or the Plan Consultant may collect personal and other information about you to provide your requested coverage and services or to process claims. The primary sources of information are you, ARTA, and your medical advisors. In order to administer or otherwise provide you the coverage and services requested, the Plan Administrator, the Policyholder, the Emergency Travel Insurance Provider, the Emergency Travel Assistance Provider, and/or the Plan Consultant may collect information from individuals, groups or companies from whom collection is necessary.

Definitions Used in this Booklet

Accident — Means any unlooked-for mishap or untoward event which is not expected or designed.

ARTA Drug Benefit List — Means the list of prescription drugs, drug products, and drug costs eligible to be covered by the ARTA Benefit Plans.

ARTARx Pharmacy — The pharmacy wholly owned by ARTA and licensed for operation by the Alberta College of Pharmacy located at 15505 137 Avenue in Edmonton, Alberta.

Annual — Means one calendar year.

Benefit Year or Calendar Year — Means the period starting January 1 and ending on December 31.

Brace — Means a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any dental brace which is used to correct a dental defect, deficiency, or injury.

Claims Adjudicator	Means Green Shield Canada.
Confinement, Confined	Means hospital confinement.
Contributory	Means the member must pay the entire insurance premium.
COPD	Chronic Obstructed Pulmonary Disease.
Couple Coverage	Means coverage for two eligible family members, including the member and one eligible dependant as defined in this section.
Covered Person	Includes a member, spouse, or dependant, as defined in this section, who is covered under this plan and for whom premium has been paid.
Currency	Means Canadian currency unless otherwise stated.
Dentist or Dental Surgeon	Means a person who is legally qualified and licensed to practice as a Dentist or Dental Surgeon in the jurisdiction where the services are rendered for which the charges are incurred.
Dependant	Refers to definition of “Eligible Dependant”.
Dependant Unit	Consists of all eligible dependants of a member.
Drug Formulary	Means medical preparations approved for use by Health Canada (Food and Drug Act), and which by law must require written prescription by a Health Care Professional and which have been approved by ARTA for inclusion in the ARTA Drug Benefit List.
Eligible Dependants	Your **spouse** may include a person married to the member as a result of a valid civil or religious ceremony, including a person divorced or separated from the member; or a person, who

although not legally married to the member, cohabits with the member in a conjugal (including same sex) relationship that has been recognized as such in the community in which they reside, and has done so for at least 12 months.

Only one person at a time may be covered as a spouse.

Your **dependant children** may include natural children, legally adopted children or children living with the adopting parents during period of probation, stepchildren, children under legal guardianship, and foster children of the member or the member's spouse. To be considered a dependant, the child must be unmarried, not employed on a regular and full-time basis, and under 21 years of age. A child up to age 25 will be considered a dependant if in full-time attendance at an accredited school, college, or university and dependent on you for support, including students attending school outside their normal Province of Residence.

Your dependant children may also include mentally or physically disabled children beyond any limiting age for dependant children provided the child is incapable of self-sustaining employment and is wholly dependent upon the member for support and maintenance.

Eligible Expenses for Students Living Away from Home

Means expenses for eligible dependants studying outside their normal province of residence will be considered under Extended Health Care Eligible Expenses on the same basis as if expenses were incurred in their province of residence. Expenses incurred by students travelling 500 kilometers or more away from their student residence and outside their normal province of residence will be considered under Emergency Travel Insurance Eligible Expenses.

Eligible Expenses

Means any expense incurred after your effective date of coverage for any covered medically necessary, reasonable and customary item of expense, of which by law can be covered in whole or in part and for which you have made application, been approved by the Plan Administrator and paid the premium.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service provided shall be considered to be both an Eligible Expense and a benefit.

Eligibility Period

Means a period of 60 days following the later of:

1) loss of employer benefits at retirement; or
2) loss of benefits from a spousal group plan or any other group plan.

Emergency Travel Assistance Provider

Means **AXA Assistance Canada**.

Emergency Travel Insurance Provider

Means **Beneva Inc**.

Evidence of Insurability

Means evidence of the person's health that must be included with an Extended Health Care application when an application is submitted after the eligibility period, or any other circumstance determined by the Emergency Travel Insurance Provider, and which require approval by the Emergency Travel Insurance Provider to provide coverage to the applicant.

Family coverage

Means coverage for three or more family members, including the member and two or more eligible dependants.

Generic Drug	Generic Drugs must contain the same active ingredients (and have similar dissolution characteristics, or bioequivalence) as the originals brand name drug.
Government Plan	Means any plan or arrangement provided by or under the administrative supervision of any government or agency thereof, which provides coverage or reimbursement for any health care service or supply and without restricting the generality of the foregoing. This includes any Provincial or Territorial Government Health Insurance Plan (GHIP), and comparable legislation in other jurisdictions.
Health Care Professional	Means a professional who is registered or licensed to practice by a governmental agency, association or college having jurisdiction over such licensing.
Hospital	Means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physicians available at all times and which continuously provides twenty-four (24) hour nursing service by graduate registered Nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, or similar establishment.
Hospital charges	Means charges made by a hospital for room and board plus charges made by the hospital for other necessary services and supplies furnished to the member or dependant for his/her use while he/she is confined. Hospital charges shall not include charges for special nursing services or for services of physicians and surgeons, or chronic care services within a hospital.

Illness	Means any disorder of the body or mind, including pregnancy related disorders.
Immediate Family Member	Means a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the above include natural, adopted or step relationship), spouse, grandson, granddaughter, grandfather or grandmother of the Covered Person.
In-province	Means in the Covered Person's province of residence in Canada.
Late Applicant	Means a Member who applies for coverage after the Eligibility Period. *(Also refer to Member Eligibility section.)*
LCA (Least Cost Alternative)	The LCA price is the lowest cost medication in an interchangeable drug grouping. Interchangeable drugs have the same therapeutic effectiveness as the other drug products in the interchangeable grouping. The ARTA Extended Health Care Plan will pay for the lowest priced drug product where interchangeable products can be used to fill a prescription (often generic drugs), including those drugs not listed in provincial formularies. If you choose higher cost alternatives, you are responsible for paying the difference in price.
Licensed, Certified or Registered	Means licensed, certified or registered to practice the profession by the appropriate authority in the jurisdiction in which the care or services are rendered; or where no such authority exist, having a certificate of competency from the professional body which regulates the particular profession.
Manufacturers' List Price	Means the price per unit of issue for a drug, a drug product, or a product which price is published in the Alberta Drug Benefit List.

Medically Necessary	Means broadly accepted by the medical profession as effective, appropriate, and essential in the diagnosis and/or treatment of a sickness or injury and based on generally recognized and accepted standards of health care.
Member	Means an eligible Regular or Affiliate Member in good standing with the Alberta Retired Teachers' Association (ARTA).
Nurse	Means a Registered Nurse (R.N.), a Licensed Practical Nurse, Psychiatric Nurse, or a Registered Nursing Assistant, who is licensed to practice nursing service by a governmental agency having jurisdiction over such licensing. A Nurse can be neither the Covered Person nor an Immediate Family Member.
Out-of-Province	Means outside the Covered Person's province or territory of residence.
Plan	Means the Alberta Retired Teachers' Association ARTARx+Travel and ARTARx Extended Health Care Benefit Plans.
Plan Administrator	The ARTA Benefit Plans are self-administered by the **Alberta Retired Teachers' Association**.
Plan Sponsor	Means the **Alberta Retired Teachers' Association Benefit Plan Trust Fund.**
Policyholder	Means the **Alberta Retired Teachers' Association.**
Policy year	Means the period of time between any two Policy Anniversaries, starting January 1 each year.

Monthly rates payable to participate in the Plan are normally renewable each November 1, unless extenuating circumstances result in changes to the plan rates at a different date.

Practitioner or Physician

Means a Doctor of Medicine (who is neither the Covered Person nor an Immediate Family Member) who is licensed to practise medicine by:

1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or
2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

Provincial or Territorial Government Health Insurance Plan (GHIP)

Means the body of provincially or territorial enacted laws, as amended from time to time, governing provincial or territorial health insurance plans, provincial or territorial hospital insurance plans, provincial or territorial Medicare plans, provincial or territorial medical care and service acts, and other provincial or territorial government sponsored hospitalization, Medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.

a Reasonable and customary charge

Means a charge made by the provider of health care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

Reasonable and customary charges are determined by the ARTA Board of Directors and are reviewed annually.

Regular Care and Attendance	Means observation and treatment to the extent necessary under existing standards of medical practice for the condition requiring such treatment or causing Hospital confinement.
Reimbursement	Means the portion of the charge of an Eligible Expense that will be reimbursed by the plan.
Remarriage	Means either of the following arrangements entered into by the surviving spouse of a deceased member: a) marriage by a valid civil or religious ceremony; or a) a "common-law marriage" in which the surviving spouse, who although not legally married to a person, cohabits with the person in a conjugal (including same sex) relationship which is recognized as such in the community where they reside.
Residence	Means the primary dwelling of which you are an occupant and the premises on which it is situated.
Single coverage	Means coverage for the Member only (no dependants).
Spouse	Refer to definition of "Eligible Dependant".
Terrorism	Means a violent act done in order to intimidate or terrorize the general public in the course of their daily lives for political ends, and does not include any act of war, civil commotion or civil unrest.
Two Years	Means a 24-month period beginning from the date of your last incurred claim; "three years" means a 36-month period, etc.
You, Your	Means a Covered Person.

Claims Information

Notice and Proof of Claim

When the Claims Adjudicator receives a written completed claim form and appropriate original receipts, payment will be made to you, for charges for Eligible Expenses, upon submission of written proof of claim, satisfactory to the Claims Adjudicator, and subject to the terms and conditions of the plan.

You must submit a pre-approval form completed by the attending physician for any treatments, services or supplies which require the prior approval of the Plan Administrator before a claim shall be paid.

Charges for Eligible Expenses submitted as a claim shall be considered to have been incurred on the date the person received the treatment, services, or supplies, or incurred an obligation with the provider for such treatment, services, or supplies.

Written proof of claim must be submitted to the Claims Adjudicator prior to the end of the Calendar Year following the year in which the claim was incurred.

On termination of your coverage for any reason, including as a result of termination of this policy, written proof of claim satisfactory to the Claims Adjudicator must be received no later than 90 days following the date of termination.

For claims information, contact the Plan Administrator.

Notice of Claim for Emergency Travel Expenses:

In the event of a medical emergency, the Travel Assistance Provider will direct you to the nearest appropriate medical facility. The Travel Assistance Provider will pay Hospitals and other medical providers directly, wherever possible, except when you choose to pay the expenses or when the medical care provider refuses to accept payment directly from the Travel Assistance Provider. **The Travel Assistance Provider must be notified within 48 hours of an Emergency, or when reasonably possible, following an Emergency. Claims may be reduced if contact is not made with the Travel Assistance Provider within 48 hours of admission to Hospital.**

In the event of any discrepancy between this booklet and the contract issued by the Emergency Travel Insurance Provider, the Emergency Travel Insurance provider contract will take precedence.

You must provide banking information upon enrollment in the Plan for the payment of your eligible claim expenses via direct deposit.

Coordination of Benefits Between Two Plans

Payment for benefits provided under the Plan will be coordinated with other benefits or payments available to you under any other health insurance policy or pre-paid plan. Payments under all policies or plans, including this plan, shall be coordinated so that total payment does not exceed 100% of the Eligible Expenses incurred. This means that when you are entitled to similar payments under one or more plans, payments under this plan will be reduced to the extent necessary so that they do not exceed 100% of Eligible Expenses incurred, after taking into account payments from the other plans.

Prescription drug claims for Chronic Care Medications not dispensed by the ARTARx Pharmacy are not coordinated with any other plans, as long as the covered person has received at least 50% reimbursement of eligible expenses.

Order of Benefit Determination

If a person is eligible to receive a benefit under the policy and the same or a similar benefit under any other contract, policy or plan, payment of benefits shall be decided in the following manner:

a) a plan without a Coordination of Benefits provision pays before a plan with a Coordination of Benefits provision;
b) when both plans contain a Coordination of Benefits provision, priority of benefit payment is attributed to the plan under which you are entitled to receive payments in the following order:
    i) first to a plan under which you are covered as a full-time or part-time employee; and
    ii) second to a retiree plan to which you are the covered participant or member; and
    iii) third to the plan that you are an eligible dependant of the covered participant or member;
    iv) a person who is a covered dependant child under more than one plan should submit to the plan where the parent whose birthday is the earlier date in Calendar Year is the covered participant or member;
    v) if priority cannot be established in the above manner, the benefit payments shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

The Plan Administrator is entitled to make payments to, and to recover payments from, other plans, as necessary in accordance with the intentions of this provision.

The Plan Administrator may (subject to your consent, if required by law) obtain from or release to any person or corporation any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement.

Right to Recover Payments

If, after benefit payments have been made to or on behalf of any Covered Person, it is discovered that, due to clerical, electronic or administrative error, payment was made inadvertently or in excess of the amount(s) required to satisfy the terms of this policy, the Claims Adjudicator reserves the right to recover the inadvertent or excess payment(s) from the Covered Person or to the organization to whom the payment was paid.

If the amount of the inadvertent or excess payment(s) cannot be recovered within a reasonable time period, the Claims Adjudicator has the right to reduce future benefit payments to or on behalf of the Covered Person until such amount(s) are recovered in full.

Subrogation from a Third Party

If the Claims Adjudicator pays any benefits in respect of a sickness or injury where a third party is liable, once you have been fully indemnified, your right of recovery shall be subrogated to the Claims Adjudicator to the extent of the benefits paid, and the Claims Adjudicator may bring action in your name to enforce such right where permitted by law.

“Fully indemnified” means that you must not only have been compensated for all losses covered by the insurance policy, but

you must also have been indemnified for your deductible, losses in excess of policy limits, and any losses that were not covered by the policy.

In such an event, you and your legal representative shall co-operate with the Claims Adjudicator to facilitate recovery and settlement of any payments, in order to satisfy the intent of this provision.

Authorization

As a Covered Person under this agreement, you, as a condition precedent to receiving benefits under this agreement, consent to, authorize and direct any person or corporation to provide the Plan Administrator with any reports, records, x-rays or other information relating to the treatment, services or supplies for which the claim is made.

Limitation of Action

In the event of a claims dispute, you must bring any legal action or proceeding against the Plan Administrator within 24 months of the date the charges were incurred. All legal actions or proceedings must be brought in the Canadian province or territory in which you permanently reside.

Duplicate Coverage

If there is any duplication of expenses between Extended Health Care coverage provided within your province of residence and Emergency Travel expenses which are incurred outside your province of residence in the event of an emergency while travelling expenses claimed shall be payable as Emergency Travel expenses, not as Extended Health Care expenses.

Claims Appeals

As an ARTA member covered by the Extended Health Care Plan you have the right to appeal your health claim if you believe the claims payment procedure was not followed correctly, or if you are unsatisfied with the claim because of ARTA policy. Contact

the Plan Administrator if you would like to learn more about claims appeals.

Fraudulent Claims

Benefits fraud can cost ARTA Covered Persons money – it may impact you by having to pay higher premiums resulting from higher claims. ARTA takes benefits fraud very seriously to prevent group benefits fraud before it happens, including using technology to detect unusual claims patterns, investigating suspicious claims, protecting the Plan against the overuse and abuse of prescriptions drugs (particularly narcotic medications), referring cases to law enforcement and regulatory bodies when appropriate, not permitting claims to be submitted by service providers who have committed fraudulent activities, and terminating ARTA membership of a Covered Person who has committed a fraudulent activity.

Covered Person fraud examples include:

- False claims submissions;
- Altered claims documents;
- Benefit card swapping or using someone else's coverage;
- Returning items after reimbursement;
- False plan eligibility information;
- Abusing narcotics by visiting multiple doctors and/or pharmacies;
- Forged or stolen prescriptions; and/or
- Out-of-country Emergency Travel claims for doctors or medical facilities that don't exist.

Service provider fraud examples include:

- Bill for treatments, products, or services that haven't been provided;
- Providing medically unnecessary treatments, products, or services;

- Providing false or altered invoices;
- Falsifying procedures performed to receive payment for non-eligible expenses;
- Unnecessary patient referrals;
- Providers who misrepresent themselves as licensed practitioners; and/or
- Billing for higher priced services or excessive use of time.

Covered Persons may help prevent fraud by doing the following:

- Keep your benefits ID cards and plan member website login information in a safe place;
- Use the ARTA Benefit Plans for its intended purpose – coverage for Eligible Expenses incurred for the medically-necessary treatment of illness or injury;
- Do not sign blank claims forms;
- Report providers who ask you to pre-sign forms to the Plan Administrator;
- Make sure the practitioner is licensed with their appropriate regulatory board;
- Do not be enticed by cash rebates or free products;
- Question and stay informed about treatments, products, or services being provided to you;
- Never submit a claim prior to receiving the medical treatment, product, or service;
- Notify and reimburse the Plan if you return previously claimed items for a refund; and
- Review the Explanation of Benefits form which accompanies your claims summary and report any concerns or billing discrepancies to ARTA's Plan Administrator.

If you suspect a service provider is acting fraudulently a tip line is available at claimswatch@hbmplus.ca or by phone at 1.800.265.5615 ext. 6921.

More information on benefits fraud can be found online at www.fraudisfraud.com.

Description of Benefits

Benefit Payments

If you incur charges for medically necessary treatment, services or supplies which are covered under this plan, the Plan Administrator will pay benefits, subject to the terms, conditions and limitations outlined in this booklet.

Benefits are payable to the extent that:

a) the charges are reasonable and customary for the services rendered and do not exceed the maximum amount specified and are paid according to the applicable Extended Health Care Summaries contained herein;
b) there is no law or legislation prohibiting insuring such services in your province or territory of residence;
c) the services were authorized in writing as medically necessary by a Practitioner or Health Care Professional operating within the scope of his or her license or registration except as otherwise stated;
d) the amount claimed is not covered, or exceeds the amount allowed under the Government Health Insurance Plan for the services provided; and
e) the charges are for treatment of an illness or injury.

Under this policy, coverage for medical expenses is supplementary to and not a replacement for coverage under your Government Health Insurance Plan in your province or territory of residence.

Extended Health Care Plan Coverage

Charges for the following services are included as Eligible Expenses for reimbursement under the ARTA Benefit Plans Extended Health Care coverage (the "Plan"). Plan details are consistent for each of the four Extended Health Care Plans, unless otherwise noted.

Eligible In-Province Expenses are reimbursed at **90%** and to the specified dollar maximum (where applicable) unless otherwise noted.

Prescription Drugs and Medicine

Reimbursement of charges to a combined maximum benefit option of **$2,500** per person per calendar year, subject to the LCA prescription drug price, at the following coverage levels:

- **100%** coverage for any eligible prescription drugs dispensed by ARTARx Pharmacy.
- **80%** coverage for acute care prescription drugs dispensed by any other licensed pharmacy.
- **Up to 50%** coverage for Chronic Care Medications dispensed by any other pharmacy. Specific Chronic Care Medications will be covered at 80% when dispensed by any other pharmacy; these specific medications include and are limited to temperature-controlled (refrigerated) products (insulin, for example), narcotics, and medications indicated for short or limited periods (for example antibiotics and certain pain-relief products).

Eligible prescription drugs and medicines covered under this plan include:

a) medically necessary drugs, sera and injectables which legally require a prescription and are approved by Health Canada, or the Provincial or Territorial Health Ministry, which:
   i) are prescribed by a Health Care Professional for the treatment of a diagnosed illness or injury; and

ii) are dispensed by a licensed pharmacist, physician or dentist legally authorized to dispense such drugs and medicines; and
iii) are included in the ARTA Drug Benefit List.

b) Prescribed smoking cessation medication.
c) Aerosol holding chambers (aerochambers).
d) Prescribed cellulose ophthalmic inserts (Lacrisert) for treatment of dry eye.
e) Prescribed vaccinations.
f) Cost of drugs administered in a physician's office for sclerotherapy treatment.
g) Low-dose (2.5mg or 5 mg) Cialis (tadalafil) for treatment of benign prostatic hyperplasia, subject to special authorization.
h) The following life-sustaining over-the-counter medications:
   i) insulin and glucagon for blood sugar management;
   ii) potassium supplements for management of hypokalemia;
   iii) injectable epinephrine used for anaphylaxis reaction management; and
   iv) nitroglycerin used for angina attack management.
i) **80%** coverage for erectile dysfunction, weight-loss medication, and hair regrowth medications, whether dispensed by ARTARx Pharmacy or any other licensed pharmacy.

Reimbursement for any single purchase is limited to the quantity that can reasonably be used in a 100-day period.

Intra-articular injection of prescribed hyaluronic acid for treatment of osteoarthritis is covered but associated expenses are not included in the annual prescription drug maximum.

The maximum dispensing fees payable under this Plan are the same for all provinces as follows:

- In accordance with current legislation, single entity drugs listed in the Alberta Drug Benefit List include two upcharges, one of which

is based on the Manufacturer List Price as published in the Alberta Drug Benefit List; single entity drugs not listed in the Alberta Drug Benefit List include two upcharges, one of which is based on the Alberta Blue Cross (ABC) Drug Price List. The maximum dispensing fees reimbursed are:

Products Listed in the Alberta Drug Benefit List

Dispensing Fee	Up to $12.15 per script
Allowable Upcharge #1	3.0% of Manufacturer List Price
Allowable Upcharge #2 (calculated on drug price plus allowable upcharge #1)	7.0% to a maximum of $100

Products Not Listed in the Alberta Drug Benefit List

Dispensing Fee	Up to $12.15 per script
Allowable Upcharge #1	7.5% of ABC Drug Price List
Allowable Upcharge #2 (calculated on drug price plus allowable upcharge #1)	7.0% to a maximum of $100

- The maximum aggregate fee charged to dispense a compound drug is based on whether the compound prescription drug was made in store or purchased from a compounding and repackaging pharmacy. Compound drugs made in store include two upcharges based on the ingredient cost; compound drugs purchased from a compounding and repackaging pharmacy include one upcharge. The maximum dispensing fees reimbursed are:

Compound Drug Made In-Store

Dispensing Fee	Up to $18.45 per script
Allowable Upcharge #1	7.5% of Ingredient Cost
Allowable Upcharge #2 (calculated on drug price plus allowable upcharge #1)	7.0% to a maximum of $100

Purchased Compound Drugs	
Dispensing Fee	Up to $12.15 per script
Allowable Upcharge #1	0%
Allowable Upcharge #2 (calculated on drug price plus allowable upcharge #1)	7.0% to a maximum of $100

Chronic Use Medications

Solid oral dose formulations, including inhaled devices with an approved Health Canada indication of use under one of the below categories:

Asthma / COPD	Blood Clots
Blood Pressure	Bowel Movement Disorders
Crohn's Disease / Colitis	Depression
Diabetic Monitoring / Administration	Hormone Replacement Therapy (HRT) / Contraceptives
Diabetes	Epilepsy
Heart Function	Hormone Disorders
High Cholesterol	Gout
Neurological Pain	Neuromuscular Disorders
Osteoporosis	Overactive Bladder
Parkinson's Disease	Psychoses
Rheumatoid Arthritis	Sleep Disorder
Stomach Hyperacidity	Thyroid Dysfunction

Dispensing Fee Payment Limit for Maintenance Medications

Dispensing fee payments are limited to a maximum of five (5) events per calendar year for each of the following maintenance medication categories:

- High blood pressure
- Anti-depressants
- Anti-lipidemic agents
- Anti-diabetic agents
- Oral contraceptives

- Thyroid agents
- Anti-asthmatics/COPD
- Hormone replacement therapy
- Overactive bladder agents

Special Authorization Prescription Drugs

Special authorization is a mechanism to provide you access to certain drugs according to defined clinical criteria. Special authorization request forms are completed by physicians and reviewed by clinical pharmacists. Prior approval must be granted to ensure coverage by special authorization.

Contact the Plan Administrator or your Physician to receive a Special Authorization application form.

Step Therapy

The Step Therapy program encourages you (and your physician) to try the less expensive therapeutically advantageous, and/or safer product in an effort to protect and optimize your treatment. Special authorization requests are available for you through your pharmacist or physician if you cannot take a first-line drug.

Accidental Dental

Services by a Dentist or Dental Surgeon to repair or replace damaged natural teeth (crowned or capped teeth are considered to be natural teeth), or to set or repair a broken or dislocated jaw when the injuries are caused by an external accidental blow to the head or mouth (and not caused by any object or food intentionally placed in the mouth), subject to a **$5,000** calendar year maximum. The injury must have occurred after the effective date of coverage under the plan and while coverage is in force.

Treatment must be completed within six (6) months following the date of the injury. No benefit will be payable for charges incurred for such services after the termination date of this policy or after the

termination date of your coverage. Chewing Accidents are not covered.

Payment for services will be based on the Fee Guide which reflects current and customary fees for General Practitioners in effect in your province or territory of residence on the date the charges were incurred.

The claim must be accompanied by one of the following:

i) an official police or accident report;

ii) a dental care claim form clearly identifying all injured teeth, the date of the accident, and an explanation of how the accident happened. Please indicate the claim is due to an accident by writing "**dental accident**" across the top of the first claim form you submit; or

iii) an emergency hospital or medical facility report.

Accidental Dental expenses incurred outside of your province of residence are not eligible for coverage if your Emergency Travel coverage insurance includes similar coverage.

Medical Aids and Appliances

Coverage for the purchase or rental of items listed below is subject to charges which are reasonable and customary for the area where incurred (as determined by the Plan Administrator's records). Claims for the following eligible aids and appliances must include written authorization from the attending Health Care Professional, as long as it is within the Health Care Professional's scope of practice and must be for therapeutic use only.

a) trusses, splints (excluding nasal splints), braces, canes, casts, catheters and supplies, artificial limbs or eyes, or breast prosthesis, and up to **two (2)** mastectomy bras per year;

b) surgical support stockings and compression garments, subject to

a maximum benefit of **$250** per person per calendar year. Support stockings may be claimed up to a maximum of $250 per stocking pair;

c) custom-made orthopaedic shoes, which are not part of a brace, and orthotics, including orthopaedic adjustments to stock items and excluding the cost of pre-manufactured footwear, subject to a maximum benefit of **$750** per person every three (3) years for orthopaedic shoes and **$300** per person every three (3) years for orthotics. Repairs and adjustments to orthotics are covered, under the orthotics three year maximum;

d) medically required supplies required as a result of a colostomy, ileostomy, or urostomy and/or for the treatment of cystic fibrosis, diabetes and Parkinson;

e) orthopaedic shoes that are attached to and form part of a brace;

f) incontinence supplies, subject to a maximum benefit of **$200** per person per calendar year;

g) a medically necessary geriatric chair or power lift chair purchased or rented from an accredited medical supplies retailer, subject to a lifetime maximum of **$1,000** per person;

h) **100%** coverage for diabetic supplies, to a maximum benefit of **$2,000** per person per calendar year. Flash and continuous blood glucose monitor readers (to a maximum of one every 24 months), sensors (up to a maximum of 30 per year), and transmitters are covered under this benefit. Insulin pump supplies, sensors, and transmitters are also covered under this benefit. Flash and continuous blood glucose monitor readers and sensors are available only for eligible plan members who are insulin dependent. There is a maximum of 1,000 diabetic test strips per year allowed for adults diagnosed with Type 2 diabetes who are not insulin dependent;

i) insulin pump, insulin pump supplies, sensors, and transmitter, to a maximum of **$5,000** every four (4) years;

j) intravenous supplies, to a maximum of **$150** per calendar year;

k) pessaries, to a maximum of **$100** every 36 months;

l) Cryo-cooling units, to a maximum of **$250** every 5 years;

m) hairpieces/wigs, for hair loss due to radiation or chemotherapy or other serious medical conditions, to a maximum of **$600** every three (3) years;

n) dressings, bandages and related supplies necessary for the treatment of a chronic medical condition to a combined maximum of **$600** per calendar year;

o) walkers, to a maximum of **$120** per calendar year, including repairs;

p) visual enhancement equipment, subject to a maximum of **$200** per two (2) years. The following prescribed medical devices and equipment will be covered under the vision enhancement benefit:

   1. An optical scanner or similar device, as recommended by a physician, designed to enable an individual with a severe vision impairment to read print;
   2. A device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, as recommended by a physician, designed exclusively for use by an individual who has a severe vision impairment; and
   3. Hand-held magnifiers.

q) manual wheelchair, to a maximum of **$2,000**, or an electric wheelchair or scooter, to a maximum of **$5,000**, every five (5) years. Transport wheelchairs are covered and combined with the five-year coverage maximum for manual wheelchairs. Repairs to wheelchairs and scooters are covered, under the applicable five year maximum;

r) hospital bed, to an annual maximum of $1,920 for a manual bed and $4,200 for an electric bed;

s) respirator ventilator;

t) positioning equipment following vitrectomy surgery, to a lifetime maximum of **$500** as pre-approved by the Plan Administrator;

u) CPAP device or similar appliance for the treatment of sleep apnea to a maximum of **$2,000** per five (5) years from the date of your first claim, including device accessories (tubes, face mask, headgear, nasal pillows, cushions, straps, filters, batteries, and battery charger), and repairs;
v) nebulizer to administer medication in the form of a mist inhaled into the lungs, to a maximum of **$150** every five (5) years, including device accessories and repairs;
w) knee scooters/knee walkers and crutches (including hands-free crutches) to a maximum of **$200** every five (5) years.

Ambulance Services

a) licensed ground ambulance to and from a local hospital **when medically necessary for emergency treatment**; and
b) emergency transportation inside your province of residence by a licensed ambulance, air-ambulance or by any other public transportation vehicle, to the nearest hospital in which the required treatment can be provided, subject to one return trip per person per calendar year.

Charges for licensed ground ambulance service to and from points of departure and arrival are also covered.

Charges for non-emergency use of an ambulance used solely as a means of transportation in lieu of other forms of transportation (i.e., taxi, bus, para-transport, are not covered).

Diagnostic and Medical Services and Supplies

Reimbursement of expenses after the eligible portion, where applicable, has been paid by your Provincial or Territorial Government Health Insurance Plan for:

a) diagnostic procedures, radiology (when not confined to a hospital), blood transfusions;
b) oxygen and its administration in both province of residence and

outside province of residence; and

c) CoaguChek monitor and test strips used with a CoaguChek monitor, as pre-approved by the Plan Administrator.

Expenses related to maintenance of equipment are not eligible for reimbursement.

Hearings Aids

Charges for the purchase of either a single or dual contact hearing aid(s), upon the written recommendation of the attending licensed, certified or registered audiologist, otolaryngologist, otologist or physician. The maximum benefit payable is **$1,500** every three (3) years. Expenses associated with hearing aid repairs, batteries and accessories (microphones, television connectivity, remote controls, dehumidifiers, and cleaning tools) are included under these maxima.

Private Duty Nursing

Reimbursement of charges to an overall maximum benefit of **$3,000** per person per calendar year for the professional services of a Registered Nurse (R.N.), a Licensed Practical Nurse, Psychiatric Nurse, or a Registered Nursing Assistant upon written recommendation of a physician and as pre-approved by the Plan Administrator, while the patient is not confined to a hospital or nursing home subject to the provision that such nurse does not ordinarily reside in the home of the member or any of the member's dependants and is not related to the member by blood or marriage. Foot care provided by a Nurse is covered under this benefit as pre-approved by the Plan Administrator, to a maximum of $75 per treatment. Custodial (i.e., housekeeping), homemaking and companion services are not covered under this benefit (see Home Care).

Prescribed Health Educational Programs

Reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a Health Care Professional, subject to a maximum of **$100** per person per

calendar year. This does not include fitness club fees and/or memberships or prescribed exercise programs.

Referral for Treatment Outside Canada

When the Covered Person is referred by a physician in Canada to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by a provincial or territorial medical plan, the following expenses in excess of any provincial or territory government plan allowance are covered for reimbursement, subject to pre-approval by ARTA.

a) reasonable and customary hospital charges for ward accommodation and for other hospital charges, subject to a maximum payment for 31 days during any one period of disability; and
b) reasonable and customary charges for the services of a physician.

Vision Care

Reimbursement of charges for the following vision care services and supplies when recommended or provided by an ophthalmologist or optometrist:

a) purchase or repair of prescription lenses, frames, and fitting of prescription eyeglasses, including prescription sunglasses and contact lenses not covered in paragraph b) below, and including monofocal, toric, and multifocal surgically implanted intraocular lenses, up to a maximum benefit of **$600** per person every two (2) years. If new prescription lenses are required due to eye surgery, additional benefits in excess of those described above will be payable up to a lifetime maximum of **$175** per person as pre-approved by the Plan Administrator, and as long as the new prescription lenses are purchased within six (6) months from the

date of surgery and a prescription is provided.

b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses, subject to an additional maximum benefit of **$200** per person every 24 months;
c) visual training or remedial exercise not covered by the provincial or territorial health plan; and
d) ocular examinations, including refraction, limited to not more than one (1) per year for dependant children, and not more than one (1) every two (2) years for other Covered Persons, up to a maximum of **$115**, unless examinations are already covered by your provincial or territorial health care plan.

Hospital Accommodation

100% reimbursement of the difference between standard ward and semi-private or private hospital accommodation charges in a licensed hospital in Canada, including a convalescent or rehabilitative hospital (not homes), limited to a maximum of **$150** per day for a semi-private room or **$187** per day for a private room (excluding charges for accommodation and care in a chronic care facility).

Home Care

After receiving an invasive medical procedure at a licensed hospital, or a hospital stay of at least 24 hours, reimbursement of home care expenses are covered up to a maximum of **$50** a day, for up to ten (10) days per incident within three (3) months immediately following release from hospital and provided in your own home – upon written recommendation of a Health Care Professional and as pre-approved by the Plan Administrator. This service may be rendered by persons without professional skills or training as long as the persons are working under the supervision of a Home Care Agency or a Home Health Care Agency. The level of care includes assisting with:

a) activities of daily living (eating, bathing, dressing);
b) ambulation and exercise;
c) self-administered medications;
d) homemaker services or home health aide services;
e) services needed to maintain or improve the Covered Person's functional ability;
f) respite care to maintain your health or safety and to provide temporary relief from care giving duties to a member of your immediate family or other unpaid person who is your primary caregiver; and/or
g) outpatient services and supplies not covered by the provincial or territorial government.

The home caretaker must not ordinarily reside in your home or any of your dependants and must not be related to you by blood or marriage.

Paramedical Services

Reimbursement of reasonable and customary charges for the services, including laser therapy, of any of the paramedical practitioners listed below when the practitioner is:

a) licensed, certified, and/or registered under their appropriate regulatory body or college (but not association); and
b) providing services within his/her recognized field.

The maximum benefit payable under the Plan per calendar year per Covered Person is **$1,400 combined** for the services provided by eligible paramedical practitioners.

In addition to the combined annual maximum, the Plan covers **$30** per calendar year per person for x-rays ordered by a Chiropractor, **$30** per calendar year per person for x-rays ordered by an

Osteopath, and **$100** per person per year for the excision of plantar warts by a Podiatrist or Chiropodist.

The Plan covers up to $250 per calendar year (included under the annual paramedical practitioner maximum benefit) for prolotherapy treatment when provided by a medical practitioner qualified to provide such services.

When applicable, benefits are only payable in excess of the yearly maximum benefit payable under your provincial or territorial plan.

A statement of diagnosis from your physician may be required.

Eligible Paramedical Practitioners

Eligible paramedical practitioners and their permissible reasonable and customary charges (based on one hour of service) include:

Paramedical Practitioner	Reasonable and Customary Charge
• Chiropractor	$85 for an assessment $55 per treatment
• Physiotherapist	$110 for an assessment $85 per treatment
• Athletic Therapist	$85 per visit
• Massage Therapist	$95 per visit
• Dietician / Nutritionist	$145 per visit
• Psychologist, Master of Social Work, Registered Social Worker, Registered Clinical Counselor, and Psychotherapist	$210 for an assessment $175 per treatment
• Speech Therapist	$155 per visit
• Naturopath	$215 for an assessment $125 per treatment (including

	prolotherapy treatment provided by a naturopath)
• Acupuncturist	$110 for an assessment $90 per treatment
• Osteopath	$125 per visit
• Audiologist	Determined by claims adjudicator
• Podiatrist / Chiropodist	$90 for an assessment $60 per treatment or x-ray $650 for podiatric surgery
• Occupational Therapist	$115 per visit

ARTACares Services

ARTACares provides support for a serious illness, injury or surgery, caregiving challenges or even something lingering such as a chronic illness. Navigating the healthcare system can be complex but there are support services available.

Through ARTACares you will be supported by a Nurse who will help guide you or a loved one by addressing your health or caregiving challenges to provide real and tangible solutions. They will assist in activating services and any supports you may need. Through a simple phone call to ARTACares, you can receive support in areas such as:

- Health Care System Navigation
- Health Advocacy
- Care Coordination
- Support for a chronic disease
- Medical Second Opinion services
- Caregiving consultations

To speak with a Nurse call 1.888.327.1500.

ARTACares is provided by HumanaCare, an Alberta-based health and wellness provider with more than 35 years of Canadian Healthcare Experience.

Member Assistance Plan

ARTA is committed to supporting members' mental health and overall well-being. The ARTA Member Assistance Program (MAP) is delivered through GreenShield Health – Counselling (formerly known as Inkblot), a Canadian provider of digital-first mental health and wellbeing services. Through your ARTA Extended Health Coverage, you and your eligible dependants are each able to set up an individual account and access 5 hours of counselling and 5 hours of couple counselling per year (each MAP year begins November 1, and ends October 31). Sessions are delivered through GreenShield Health – Counselling's secure and encrypted video platform, by phone, or in-person (where feasible). Advisory services on topics including legal, financial, health, career, and life transitions are also available.

Access to the MAP is available via www.arta-map.net.

Virtual Physician Services

Virtual physician services are provided by GreenShield Health – Telemedicine (formerly known as Maple Inc.). Virtual care allows patients to meet with a physician online using smartphones, computers, and tablets. Virtual physician services are meant to supplement in-person visits with a family physician. They are especially useful for people with reduced mobility, or people in rural areas who may not have easy access to physicians. Virtual physicians have access to each member's provincial health care records, can prescribe medications, order requisitions, and diagnose ailments.

Emergency Travel Insurance *(ARTARx+Travel Plan only)*

Please refer to the Emergency Travel Policy Number 1TN25. For coverage details, please refer to www.artabenefits.net.

Exclusions and Limitations

Benefits are not payable inside Canada for or expenses resulting from:

1. Services which are insured by your provincial or territorial government health plan or expenses which the ARTA Benefit Plans is not permitted, by any law or regulation, to cover; or government actions implemented during the policy year which may impact the Plan.
2. General health examinations and examinations required for use of a third party.
3. Eye examinations, except where included as an Eligible Expense.
4. A surgical procedure or treatment performed primarily for cosmetic reasons, or charges for hospital confinement for such surgical procedure or treatment unless such surgery or treatment is for accidental injuries and begins within 90 days of the accident.
5. Medical treatment or surgical procedures by a physician other than described under Physicians' Services in the Benefits Section.
6. Expenses incurred by a physician, dentist or denturist expenses for travel time, broken appointments, transportation costs, completion of insurance forms, room rental charges or consultation received by any telecommunication means, other than as specifically provided under Eligible Expenses.
7. Unspecified items in the foregoing lists of Eligible Expenses.
8. Services or supplies which are furnished without the recommendation, unless specified otherwise, and approval of a Health Care Professional acting within the scope of his/her license.
9. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, disease, or pregnancy.
10. Services or treatment for occupational injuries or diseases covered by any Workers' Compensation law or similar legislation.
11. Expenses which would not normally have been incurred but for the presence of this insurance or for which you or your dependant is not legally obligated to pay.
12. Dental work where a third party is responsible for payment of such charges.
13. Services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of committing, attempting, or provoking an assault or criminal offence.

14. Services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of a war or act of war (whether declared or undeclared), service in the armed forces of any country, insurrection or riot, or hostilities of any kind.
15. Services or supplies for treatment of injuries that are intentionally self-inflicted.
16. Drugs, sera, injectable drugs or supplies which are not approved by Health Canada (Food & Drug Act), or that are experimental or limited in use whether or not so approved.
17. Non-life-sustaining over-the-counter medications.
18. Costs associated with the administration of drugs which are not covered by a Provincial or Territorial Government Health Insurance Plan.
19. Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society.
20. Charges for drugs that can be purchased without a Health Care Professional's prescription, whether or not a Health Care Professional has prescribed them, unless otherwise noted in this booklet.
21. Accommodation in a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, or a chronic care facility.
22. Nursing home services provided in a nursing home.
23. Emergency Travel Insurance expenses if this coverage option has not been elected.
24. Medication used to treat infertility.
25. Charges for Victoza (liraglutide) for treatment of diabetes.
26. Any written orders for services or devices provided by a Health Care Professional which is not within the scope of practice of the Health Care Professional providing the written order.
27. Coverage for hearing aid batteries requires a written order issued by a licensed, certified or registered audiologist, otolaryngologist, otologist or physician if the claimant has not previously submitted a claim for hearing aids.
28. The overall combined allowable charges for wheelchairs cannot exceed $5,000 over a five (5) year period.
29. Expenses incurred for platelet rich plasma therapy.

Summary of Providers and Contact Information

This Extended Health Care Plan was developed and is sponsored and administered by ARTA. Green Shield Canada provides claims adjudication services. Emergency Travel Assistance is provided by AXA Assistance Canada. Emergency Travel insurance is underwritten by Beneva Inc. If you require additional information, or if you have any questions concerning this Plan, please contact ARTA:

15505 137 Avenue NW
Edmonton, AB T5V 1R9
Phone: 780.989.8709
Administration and Claims Toll-free: 1.855.444.ARTA (2782)
General Enquiries E-mail: info@arta.net
Claims Enquiries E-mail: claims@arta.net
Web: www.arta.net

IN THE EVENT OF A MEDICAL EMERGENCY WHILE TRAVELLING

If you are enrolled in ARTARx+Travel, at the first onset of a medical emergency, you must contact the 24-hour AXA Assistance Canada emergency help line for direction to the nearest appropriate medical facility. AXA Assistance Canada will pay Hospitals and other medical providers directly, wherever possible, except when you choose to pay the expenses or when the medical care provider refuses to accept payment directly from AXA Assistance Canada.

Toll-free in Canada/U.S.: 1.844.996.9003
From any other country, call collect: 1.519.342.0142 (using correct international calling prefix, depending on where you are calling from)

IMPORTANT TO REMEMBER!

AXA Assistance Canada must be notified within 48 hours of an Emergency, or when reasonably possible, following an Emergency. Claims may be reduced if contact is not made with AXA Assistance Canada within 48 hours of admission to Hospital.