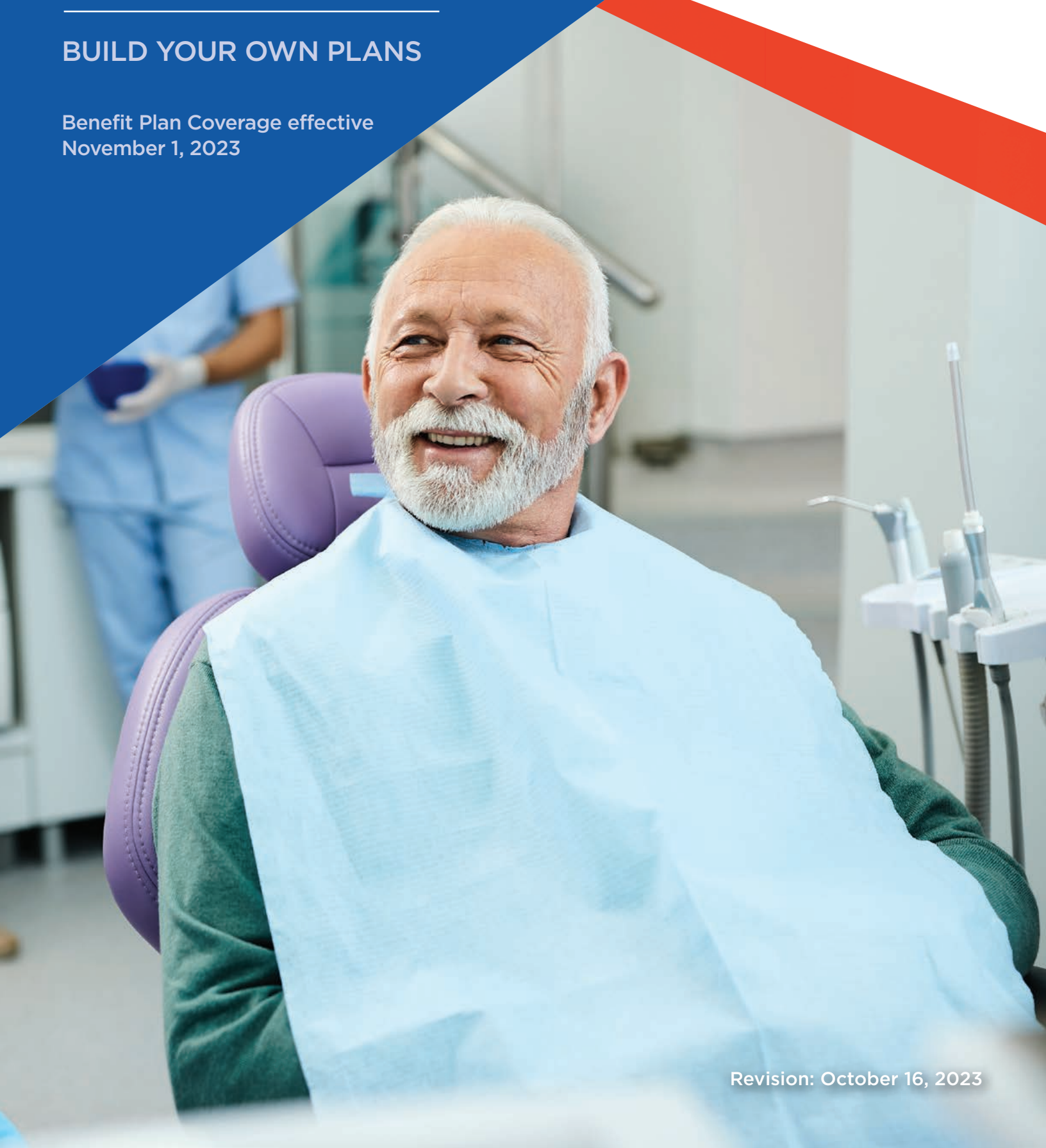
DENTAL CARE PLAN

ARTA BENEFIT PLANS

BUILD YOUR OWN PLANS

Benefit Plan Coverage effective
November 1, 2023



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Dental Care Plan Summaries

Plan Provision	Option A	Option B	Option C
Deductible	None	None	None
Basic & Preventative Services Coverage Level	80%	80%	65%
Basic & Preventative Services Annual Maximum	No annual maximum	No annual maximum	No annual maximum
Minor Restorative Services Coverage Level	80%	80%	65%
Minor Restorative Services Calendar Year Maximum	$750	$750	$750
Major Restorative Services Coverage Level	50%	No coverage	No coverage
Major Restorative Services Calendar Year Maximum	$1,600 combined for crowns, posts, inlays, onlays, bridges, dentures, and implants	N/A	N/A
Scaling and/or Root Planing	8 Units per year	8 Units per year	8 Units per year
Oral Examinations	Once per year	Once per year	Once per year
Schedule of Fees	Current Alberta Dental Association Fee Guide*	Current Alberta Dental Association Fee Guide*	Current Alberta Dental Association Fee Guide*
Dental Facility Fees	4 Units per year	4 Units per year	4 Units per year

* The basis of payment for Plan participants is the current Alberta Dental Association & College Dental Fee Guide beginning April 1, 2022. The basis of payment for eligible Dental services incurred prior to April 1, 2022, is the 2016 ARTA Usual & Customary Fee Schedule.

General Information

About this Booklet

The information contained in this booklet is important to you. It provides the information you need about the Build-Your-Own Dental Care benefits available through the Alberta Retired Teachers' Association (ARTA) Benefit Plans.

Your Dental Care benefit 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 Dental Care benefits, please contact ARTA's Plan Administrator.

ARTA self-insures all non-emergent Dental Care benefits. This means ARTA has sole legal and financial liability for the Dental Care claims.

This booklet also serves as the Plan Text for the administration of the ARTA Dental Care Plan.

Member Eligibility

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

- a permanent resident of Canada; and
- an ARTA member in good standing.

The definition of an ARTA member 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 a separate 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 this Plan while you have similar coverage in place under a separate 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 this 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 termination date (the Eligibility Period) in order to qualify for coverage without proration of benefits. 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. As a Late Applicant, your maximum amount of benefit payable for Minor and Major Restorative services is prorated from the date your application is received to December 31st of your first calendar year of coverage. After

December 31st of your first calendar year of coverage, the annual maximum payable will be as indicated in the Plan Summary. Your coverage shall become effective on the date the Plan Administrator approves your completed application.

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.

This Plan is not available to members residing in the province of Quebec.

Dependant Eligibility

Your dependants become eligible for coverage on the date you become eligible 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.

If 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 for coverage.

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

Your eligible dependent children shall be covered as dependants of only one member even though you and your spouse may

qualify to be covered as eligible members. Your spouse cannot be covered as a dependant if also covered as a member.

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 dependent children acquired resulting from the Remarriage will be eligible for coverage, subject to the Eligibility provisions for dependants.

Participation Requirements

Upon initial enrolment you can choose between Dental Care Plan Options A, B or C. You are required to remain covered under the selected Plan Option for a minimum period of at least 24 months from the effective date of coverage under that Plan Option prior to reducing coverage (for example, reducing coverage from Plan Option A to Plan Option B) or terminating your coverage. You may improve your coverage at any time (for example, improving coverage from Plan Option B to Plan Option A), but you are required to remain covered at that new Plan Option for at least 24 months from the effective date of coverage under that Plan Option.

Premium Payments

Your 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. Premiums are not charged and refunds are not allowed for partial months. Retroactive refund of premiums is limited to 12 months.

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 handled 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 more than three (3) consecutive months due to non-payment of premium, the Plan Administrator will not entertain an application for resumption 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 Policyholder;
b) the date you request in writing to terminate coverage;
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 Policyholder;
b) the date you request in writing to terminate dependant coverage;
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 treatment, or the failure of a Covered Person to obtain 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 and Provincial 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, 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, 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.
Annual	Means one calendar year.
Calendar Year	Means the period starting January 1 and ending on December 31.
Claims Adjudicator	Means Green Shield Canada.
Contributory	Means the member must pay part or the entire insurance premium.
Couple Coverage	Means coverage for two eligible family members, including the member and one eligible dependant
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.
Dental Hygienist	Means a person whom while operating under the direction or supervision of a dentist, is duly licensed to perform designated services as outlined by governing provincial licensing body.
Dentist	Means a person who is legally qualified and licensed to practice as a Dentist in the jurisdiction where the services are rendered for which the charges are incurred.

Denture Therapist Means a person legally qualified and licensed to engage in the practice of denture therapy 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.

Due Proof Means written evidence of loss satisfactory to the Plan Administrator.

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 handicapped 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

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.

Family coverage

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

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.

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.
Injury	Means bodily injury caused by external, violent and accidental means.
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.
Member	Means an eligible Regular or Affiliate Member in good standing with the Alberta Retired Teachers' Association (ARTA).
Out-of-Province	Means outside the Covered Person's province of residence.
Periodontal Treatment	Means treatment of the tissues and bones supporting the teeth, including surgery, provisional splinting, and occlusal equilibration.
Plan	Means the Alberta Retired Teachers' Association Build-Your-Own Dental Care Benefit Plan.
Plan Administrator	The ARTA Benefits 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 September 1 unless extenuating circumstances result in changes to the plan rates at a different date.
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.
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 b) 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.
Single coverage	Means coverage for the member only (no dependants).
Spouse	Refers to definition of "Eligible Dependant"
Two Consecutive Calendar Years	Means two calendar years beginning with the calendar year of your last incurred claim.

Two Consecutive Years	Means a 24-month period beginning from the date of your last incurred claim and “three consecutive years” means a 36-month period, etc.
You, Your	Means a Covered Person.
Unit	Means a time unit equal to 15 minutes.

Claims Information

Notice and Proof of Claim

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

You must submit a pre-authorization form completed by the attending dental practitioner 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 Plan Administrator by 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 Plan Administrator must be received no later than 90 days following the date of termination.

Failure to give notice of claim or furnish proof of claim within the time prescribed herein does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date a claim arises

hereunder, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

For claims information, contact the Plan Administrator.

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 dental 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.

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 so 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator to the extent of the benefits paid, and the Plan Administrator 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 Plan Administrator 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, authorizes and directs 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.

Claims Appeals

As an ARTA member covered by the Dental 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; and/or
- False plan eligibility information.

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 Plan 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 necessary dental treatment, services or supplies by a licensed dentist, qualified dental hygienist or denturist, the Plan Administrator will pay based on the current provincial fee guide for General Practitioners or the Denturist Fee Guide, whichever is applicable, on the date the charges are incurred, in accordance with the benefits outlined in the Dental Care Summaries and as follows.

Calendar Year Maximum

The maximum amount payable by the Plan Administrator for Eligible Expenses to or on behalf of a Covered Person during a calendar year is as outlined in the Plan Summaries for Minor Restorative Procedures and for Major Restorative Procedures.

If a person becomes covered more than 60 days after first becoming eligible under this insurance policy, the maximum amount of benefit payable for minor and major restorative services is prorated from the date the Application is received to December 31st of the first calendar year of coverage.

Reimbursement Level

The reimbursement level is the percentage of the eligible expense shown in the Plan Summaries, for each type of dental procedure.

Basic Preventative Procedures and Restorative Procedures

a) standard oral examinations, recall oral examinations, one (1) Unit of polishing, oral hygiene instruction, and topical fluoride application (including fluoride varnish treatment), once every calendar year for each procedure, and up to eight (8) Units of scaling and / or root planning. Up to ten (10) additional units of scaling per year are available if you have an underlying health condition which requires additional scaling in order to prevent infection, with a physician's referral;

b) complete oral examinations once every three (3) calendar years;
c) dental x-rays are limited to six (6) films every calendar year, and full-mouth and panoramic x-rays are each limited to once every three (3) calendar years;
d) consultations;
e) acid etch space maintainers;
f) amalgam, silicate, acrylic, and composite fillings and veneer applications;
g) retentive pins;
h) surgical extractions of erupted and impacted teeth and removal of residual roots;
i) surgical removal of tumours, cysts and neoplasms; incision and drainage of abscesses;
j) general anesthesia, including four (4) Units of facility fees per calendar year; and
k) relining, rebasing and repair of dentures.

Minor Restorative Procedures

Reimbursement for the following Minor Restorative Procedure charges:

a) endodontics (treatment of dental pulp diseases, including root canal therapy); and
b) periodontics (treatment of bones and tissues supporting teeth, including surgery, provisional splinting and occlusal equilibration), subject to the following limits:
    i. occlusal equilibration is payable up to a maximum benefit of $250 per Covered Person per calendar year;
    ii. periodontal recall exam twice per calendar year;
    iii. periodontal appliances and adjustments are limited to one (1) every three (3) calendar years.

Major Restorative Procedures (Option "A" Only)

Crowns/Posts/Inlays/Onlays:

Reimbursement for the following Major Restorative Procedure charges (including any related laboratory fees):

a) Crowns (including crowns on implants);
b) Posts;
c) Inlays; and
d) Onlays.

Reimbursement of the above charges is restricted to the condition that treatment is performed to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling.

When a tooth can be restored with amalgam, silicate, acrylic or composite restorations, benefits will be determined based on the usual costs of such a restoration. The cost of a temporary crown or bridge will be deducted from the reimbursement for the fixed crown or bridge.

Bridgework/Dentures/Implants:

Reimbursement for the following Major Restorative Procedure charges (including any related laboratory fees):

a) Initial installation or repair of a fixed bridge; and
b) Replacement of an existing fixed bridge if:
    i. necessitated by the extraction, loss or fracture of an additional natural tooth while covered under this plan;
    ii. the existing bridge is at least three (3) years old, and cannot be made serviceable; or
    iii. the existing bridge is temporary and is replaced by a permanent bridge within 12 months of its installation.
c) Initial installation of partial or complete dentures; and
d) Replacement of an existing denture if:

i. necessitated by the extraction, loss or fracture of an additional natural tooth while covered under this plan;
ii. the existing denture is at least three years old, and cannot be made serviceable; or
iii. The existing denture is temporary and is replaced by a permanent bridge within 12 months of its installation.

e) Initial provision of Implants); and
f) Replacement of Implants, providing the existing implant is at least 60 months old.

Limitation on Benefits Provided Outside of Province of Residence / Canada

Dental services rendered outside of a covered member's province of residence, in other Canadian provinces or territories or outside Canada, will be reimbursed based on the current applicable fee guide used by ARTA.

Alternate Treatment Clause

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the Plan Administrator will pay benefits as if the least expensive course of treatment were used. The Plan Administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Pre-treatment Plan (Pre-determination)

To ensure that eligible charges incurred are covered, it is recommended that the Covered Person submit a pre-treatment plan and submit to the Plan Administrator for approval on proposed dental treatment that exceeds $300, prior to commencing the treatment.

A pre-treatment plan should include the itemized services to be performed, the itemized charges for each service and when required be supported by x-rays.

Exclusions and Limitations

Benefits are not payable for:

1. Any services which are covered by any government plan or program; or for which no charge is made; or which the Plan Administrator is not permitted by law to cover; or government actions implemented during the year which may impact the plan.
2. Any dental examinations required by a third party.
3. A surgical procedure or treatment performed primarily for cosmetic reasons, unless such surgery or treatment is for accidental injuries and begins within 90 days of the accident.
4. Expenses incurred by physician, dentist or denturist expenses for travel time, broken appointments, transportation cost, completion of claim forms, room rental charges or consultation received by any telecommunication means, other than as specifically provided under Eligible Expenses.
5. Unspecified items in the foregoing lists of Eligible Expenses.
6. Services or supplies which are furnished without the recommendation and approval of a legally qualified dentist or denturist acting within the scope of his/her license.
7. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy.
8. Services or treatment for occupational injuries or diseases covered by any Workers' Compensation law or similar legislation.
9. Expenses which would not normally have been incurred but for the presence of this coverage or for which you are not legally obligated to pay.
10. 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.
11. 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.
12. Services or supplies for treatment of injuries that are intentionally self-inflicted.
13. Drugs, sera, injectable drugs, or supplies which are not approved by Health & Welfare Canada (Food & Drug), or that are experimental or limited in use whether or not so approved.

14. Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society.
15. Any hospital charges for board and room and related services and supplies.
16. Services or supplies in connection with any procedures excluded as Eligible Expenses.
17. Services or supplies for or in connection with orthodontic treatment.
18. Replacement of an existing appliance that has been lost, mislaid or stolen.
19. Services or supplies for full-mouth reconstruction, vertical dimension correction, or correction of temporomandibular joint (TMJ) dysfunction.
20. Dental treatment received from an employer, association, or labour union maintained health or dental plan.
21. Implants or any service or supplies related to Implants, unless specified as an eligible expense.
22. Fees charged for eligible services, which are in excess of the Dental Fee Guide indicated in the Plan Summary Schedule of Fees.
23. Major Restorative Treatment is excluded for persons covered under Dental Plan Options B or C.

Summary of Providers and Contact Information

This Dental Care Plan was developed and is sponsored and administered by ARTA. Green Shield Canada provides claims adjudication services. If you require additional information, or if you have any questions concerning this ARTA Plan, please contact the ARTA's Plan Administrator:

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