Retiree Extended Health, Dental and Semi-Private Hospital Benefits

MTS allstream

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MTS Allstream Retiree Extended Health, Dental and Semi-Private Hospital Benefits

The information contained in this booklet is important to you and your family and should be kept in a safe place. You should familiarize yourself with the contents of the booklet and refer to it whenever you have questions about your benefit coverage.

Important Notice:
This information booklet has been prepared to give you an informal summary of the main features of MTS Allstream's Extended Health, Dental and Semi-Private Hospital coverage for retirees. The statements in this booklet are not part of the master policies and are not terms of an insurance contract. This booklet does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Policies and by applicable Laws.

This booklet describes the benefits and coverage in effect as of August 1, 2009. Any changes to the government medicare plans, any new medical and dental services, and any new prescription drugs brought to market after August 1, 2009 will not automatically be covered by the Company's benefit program. Periodically, the Company will review the benefits and coverage in effect, as well as any new services that become available, and continues to reserve the right to improve, amend or discontinue all or any part of the benefit program at any time, and from time to time.

If you require additional information about your benefits or a supply of claim forms, please contact the MTS Allstream Benefits Hotline at **1-800-276-7630**.

Inside

General Information

Your Extended Health, Dental and Semi-Private Hospital benefits are designed to supplement the basic protection provided by your provincial health insurance plan.

Enrollment

Participation in MTS Allstream's retiree Extended Health, Dental and Semi-Private Hospital Plans is optional (except in Quebec where you must participate in Extended Health if you are under age 65 and do not have prescription drug coverage elsewhere).

When you retire, you will complete an enrollment form indicating which, if any, of these plans you wish to join and at what coverage level. Read this material carefully to determine which plans are available to you. You may choose one of three coverage categories for any plan:

- Single – coverage for you only
- Couple – coverage for you and one eligible dependent (your spouse or a child)
- Family – coverage for you and two or more eligible dependents

If you wish to cover your eligible dependents under any plan, you must complete the dependent information section of the enrollment form. If you do not register your dependents, they will not be covered.

If you opt out of Extended Health or Dental coverage, you may not join in the future. If you opt out of Semi-Private Hospital coverage, you may re-apply for coverage later, but your coverage will be subject to evidence of good health, unless the new application is received within 31 days of a lifestyle change.

Pensioners, who did not retire out of active employment, who had 25 years or more of service in the Allstream Contributory or Non-Contributory pension plan are allowed to join the EHC Plan A, Dental or Semi-Private Hospital Plan if they:

1. are in receipt of monthly pension benefits from the Allstream pension plan;
2. provide EOI (evidence of insurability — required by the insurance company);
3. provide proof of attainment of 25 years or more of service in the Contributory or Non-Contributory pension plan.

Note:

If you live in Quebec and are age 65 or older, you are eligible for prescription drug coverage under the Régie de l'assurance-maladie du Québec (RAMQ). If you are not enrolled in the RAMQ drug plan, you will be required to pay a higher contribution for MTS Allstream's Extended Health coverage. For more information about the RAMQ drug plan, contact the MTS Allstream Benefits Hotline at 1-800-276-7630 or your local RAMQ office.

NOTE:

An unmarried child of your spouse is considered a dependent only if he or she is also your child, or your spouse is living with you and has custody of the child.

The plan does not cover

- any child who is working more than 30 hours a week, unless he/she is a full-time student, or
- a spouse or child who is not resident in Canada. (A dependent child studying outside Canada remains covered provided he or she retains provincial health insurance coverage.)

Cost of Coverage

Contribution rates for retiree Extended Health, Dental and Semi-Private Hospital benefits are determined each year, based on claims and expenses experienced under these plans.

MTS Allstream provides a fixed subsidy of $30 a month ($360 a year) toward the cost of Extended Health coverage for retirees enrolled in the Plan as of March 1, 2002. You are required to pay the balance of the cost of any coverage you select. If you live in Ontario or Quebec, you are also required to pay provincial sales taxes, currently 8% in Ontario and 9% in Quebec.

MTS Allstream employees who retire after March 1, 2002 are not eligible for the company subsidy and must pay 100% of the cost of any coverage they select.

Eligible Dependents

Your eligible dependents include:

- Your spouse (legal or common-law). This is the person who is either:
  1. Legally married to you.
  2. A common-law spouse of either sex with whom you have been living in a conjugal relationship for a minimum of 12 months. Your common-law spouse may be eligible from the earlier birth or adoption of a child of the relationship.

In the event that there is both a spouse and a common-law spouse, MTS Allstream will recognize, for plan coverage, the individual designated by you.

- Your unmarried children or your spouse's unmarried children who are entirely dependent on you for support, who are under 21 years of age, or over 21 but under 25* and in full-time attendance at a university or similar institution.
- Your unmarried children or your spouse's unmarried children 21 years of age or over who are incapable of supporting themselves because of a mental or physical handicap, and are entirely dependent on you for support, provided the handicap occurred prior to age 21 or age 25* while in full-time attendance at a university or similar institution.

*Age 26 in Quebec for Extended Health benefits.

Changing Your Coverage Category

You may change your coverage category (single, couple, family) under any plan whenever you experience a designated lifestyle change, including:

- Marriage or 12 months in a common-law relationship;
- Separation, divorce or termination of a common-law relationship;
- Birth, adoption or change in dependency of a child;
- Death of a spouse or child;
- Termination of your spouse's coverage under another employer's plan;
- Last dependent child no longer eligible for coverage.

In The Event Of Your Death

Extended Health, Dental and Semi-Private Hospital coverage (if elected) will continue for eligible expenses incurred by your covered dependents within 31 days after the date of your death, provided this provision continues in force. If your spouse was a covered dependent prior to your death, he/she may continue coverage after that by paying premiums directly to the Company. If your spouse qualifies for a Survivor Pension, premiums may be deducted from his/her monthly pension.

To change your coverage category, you must contact the MTS Allstream Retiree Benefits Helpline at 1-800-276-7630 within 31 days of the event. After 31 days, evidence of good health will be required to add a dependent to your Extended Health coverage (except in Quebec where you are not required to provide evidence of good health for your dependents for Extended Health coverage), obtain Semi-Private Hospital coverage or add a dependent to that coverage.

Co-Ordination of Benefits

If you and your spouse both have Extended Health or Dental coverage, you may receive reimbursement for an incurred expense from both plans, provided the total paid by both insurers is not greater than 100% of the incurred expense.

Co-ordination of Benefits is a method of determining the amount payable by each plan when a claimant is covered under two or more group health plans. The insurance industry has developed guidelines to determine which plan is *primary* (pays first) and which is *secondary* (pays the balance of the allowable expense incurred).

Here is a practical way that the co-ordination of benefit plans can work for you:

- Re-submit claims to the other spouse's plan when only partial coverage of a claim results. For example, if eyeglasses were purchased for an amount in excess of the $300 maximum, the amount in excess of $300 can be submitted to the spouse's plan.
- In this approach, you submit your claims to your plan first, then submit the unpaid balance to your spouse's plan.
- Claims for dependent children should be submitted to the plan of the spouse with the earlier birth month and day (regardless of year), and then to the other spouse's plan to determine eligibility for further reimbursement.

If you and your spouse both have couple or family coverage in the MTS Allstream Extended Health or Dental Plan, you are both eligible to co-ordinate your benefits under this provision.

For more information on co-ordination of benefits, please contact the MTS Allstream Benefits Hotline at 1-800-276-7630 or Great-West Life at 1-800-263-5742 and refer to Policy #55410 (Healthcare Expenses) or Policy #55411 (Dental Expenses).

Extended Health Plan

The Extended Health plan provides coverage for a broad range of expenses not covered by your provincial health insurance plan.

Note:

The Extended Health Plan will not reimburse an expense that is payable under a provincial plan.

Plan A

All employees retiring after March 1, 2002, who elect extended health benefits, will be covered under this plan.

Plan B

All employees retired up to March 1, 2002, who elected extended health benefits, will be covered under this plan, unless they elected to opt out and join Plan A.

Retirees currently covered under Plan B may remain covered under this plan or elect to switch to Plan A. Once a retiree has switched to Plan A, (s)he may not switch back to Plan B.

You may opt out of either plan at any time (unless you live in Quebec, where you must participate in Extended Health if you are under age 65 and do not have prescription drug coverage elsewhere). However, the decision to opt out is final and you will not have the opportunity to join again in the future.

	Plan A	Plan B
Annual deductible (prescription drugs only)	Single: $100 Couple: $200 Family: $250	Single: $25 Couple: $50 Family: $65
Reimbursement level	100% of vision care and out-of-province emergency expenses and 75% of supplementary healthcare expenses (subject to specified limits)	100% of all eligible expenses(subject to specified limits)
Annual out-of-pocket limit (prescription drugs only)	Single: $ 750 Couple: $1,500 Family: $1,875	Not applicable
Vision care	Up to $300/person every two years	
Out-of-province emergency expenses	The first 60 days of a trip, to a lifetime maximum of $1 million (includes Emergency Travel Assistance)	
Supplementary healthcare expenses:		
Prescription drugs	$5 dispensing fee cap	
Private nursing	Up to $6,000 per person per illness or injury	
Paramedical practitioners	Up to $400 per person/year/type of practitioner	
Psychologist	$1,000/person/year	
Speech therapist	Up to 20 visits/person/year	
Hearing aids	Up to $300/person every two years	
Supplies and appliances	Wheelchairs, hospital beds, splints, canes, walkers, crutches, casts, orthopedic shoes, external breast prostheses, elastic support hose	

If your out-of-pocket prescription drug expenses (including your deductible) reach your annual out-of-pocket limit in any year, Plan A will reimburse 100% of any additional prescription drug expenses for the balance of that year.

Covered paramedical practioners include: chiropractor, chiropodist, podiatrist, osteopath, naturopath, physiotherapist.

Vision Care Benefits

- Eye examinations by an ophthalmologist or optometrist, limited to one examination in a 24-month period (12-month period for a dependent under age 18).
- Eyeglasses or contact lenses selected in place of eyeglasses which are prescribed by an ophthalmologist or optometrist, to a maximum of $300 in each 24-month period.
- Contact lenses (up to a lifetime maximum of $225 during the entire time the person is covered) if they are prescribed because the cornea is impaired in some way, and if visual acuity cannot be improved to at least the 20/40 level in the better eye with eyeglasses.
- Visual training or remedial therapy to correct faulty visual skills, to a lifetime maximum of $225, but only for residents in a province in which the provincial health insurance plan does not cover such services in whole or part.
- Eyeglasses and contact lenses, including foldable lenses, certified by an ophthalmologist as necessary due to the treatment of keratoconus or any other surgical procedure, limited to $200 for the non-surgical treatment of keratoconus for the lifetime of the member and each insured dependent, and $200 for expenses incurred within six months of each surgical procedure.

Supplementary Healthcare Benefits

Plan A, reimburses 75% of eligible expenses and Plan B reimburses 100% of eligible expenses, subject to specified limits. You must meet a yearly deductible before prescription drug coverage begins (see table on page 4 for details). In all cases, coverage is based on reasonable and customary expenses.

Under Plan A, there is an annual out-of-pocket limit for prescription drug expenses ($750 for single coverage, $1,500 for couple coverage and $1,875 for family coverage). If your out-of-pocket expenses for prescription drugs (including your prescription drug deductible) reach your annual out-of-pocket limit in any year, Plan A will reimburse 100% of any additional prescription drug expenses for the balance of that year.

- **Out-of-Hospital Nursing:** in-home care by a registered nurse or a registered nursing assistant or a certified nursing assistant or a licensed practical nurse who is not a member of your family and does not ordinarily reside in your home. Not included are services of a custodial nature or which do not require the specific skills of a registered nurse, registered nursing assistant, certified nursing assistant or licensed practical nurse. Reimbursement is limited to $6,000 per eligible person for any illness or injury provided this level of coverage is required.
- **Prescription Drugs:** drugs and medicines obtainable only through a physician's prescription, including hormonal contraceptives. Patent medicines and over-the-counter drugs are not normally covered, regardless of whether you have a written prescription. **The maximum amount payable for dispensing fees is $5.00 per prescription.** In an effort to contain costs, generic drug substitution will be mandatory in all cases where an equally therapeutic drug is available. Brand name drugs will also be covered in instances where your doctor has indicated on the prescription form that there must be no substitution.

  The benefit payable for smoking cessation drugs is limited to a lifetime maximum of $500 per person, except in Quebec where benefits are paid in accordance with the requirements of the Act respecting prescription drug insurance.

  If you are covered under a provincial drug plan and you have drug expenses exceeding that plan's deductible, you should submit claims to the provincial plan. You may then re-submit your bills to the MTS Allstream plan for payment of the balance of your eligible expenses.

- **Paramedical Services:** services of a licensed chiropractor, chiropodist, podiatrist, osteopath, naturopath or physiotherapist, where they are not covered by your provincial health insurance plan. This coverage is limited to $400 per person, per calendar year for each type of practitioner.

  Services will be covered only after you have reached the maximum number of visits covered by your provincial health insurance plan.

- **Psychologists' Services:** out-of-hospital services of a licensed psychologist, up to **a maximum of $1,000 per person each calendar year**.

- **Speech Therapy:** out-of-hospital services of a qualified speech therapist for the correction of speech impairments, up to **a maximum of 20 visits per person per calendar year**.

- **Supplies, Appliances and Prosthetic Devices:** rental or, at MTS Allstream's discretion, purchase of supplies, appliances and prosthetic devices prescribed by a physician including, but not limited to, the following: wheelchairs, hospital beds, splints, canes, walkers, crutches, casts, orthopedic shoes (limited to one pair per calendar year), external breast prostheses, (limited to two every 24 months following mastectomy), insulin, insulin syringe and chemical testing supplies for diabetics.

- **Hearing Aids:** hearing aids obtained through a written prescription of an otolaryngologist, up to **a maximum payment of $300 per person in any 24-month period**.

- **Dental Treatment:** out-of-hospital treatment of accidental injury to natural teeth, provided coverage is still in force and treatment is completed by the later of age 20 or 12 months after the accident.

- **Ambulance Service:** transportation by licensed ground ambulance or emergency air ambulance to the nearest hospital equipped to provide required treatment, where the physical condition of the patient prevents the use of another means of transportation.

- **Miscellaneous Expenses:** radium and radioactive isotope treatment, surgical dressings, elastic support hose prescribed by a physician.

Out-of-Province/Country Benefits

- **Out-of-Province/Country Coverage:** expenses incurred outside the person's province of residence (Canada, U.S.A. and International) are covered only if they are medically necessary and are required for emergency treatment of an injury or disease which occurs while you or your dependent is temporarily out-of-province on a trip. The charges must be reasonable and customary for the area in which they are provided.

  Coverage includes:

  – hospital and medical expenses in excess of those covered by your provincial health insurance plan.

  – a 24-hour helpline for assistance with physician and hospital referrals and other travel-related emergencies.

  – coverage for travel expenses incurred by family members as a result of a medical emergency.

- **Out-of-Province/Country Emergency Maximum:** the maximum lifetime amount payable for you and each insured dependent is $1,000,000.

- **Out-of-Province/Country Referral:** expenses incurred for required medical treatment which are not offered in your province of residence and you are forced to seek such treatment elsewhere. Medical expenses incurred outside of Canada are eligible only if those medical services are not offered in any province in Canada. The charges must be reasonable and customary for the area in which they are provided. In this event, the plan pays the difference between the actual charges and any expenses normally payable by your provincial health insurance plan, limited to $75 a day for 60 days in a calendar year.

Note:

Out-of-Province/Country coverage is limited to emergency care benefits while you are temporarily out of the province/country, provided you have maintained coverage under your provincial health insurance plan. This coverage is in effect for a period of 60 days, beginning the day you depart from your province of residence. Once the 60-day period has expired, you must return to your home province before you can reactivate the 60-day coverage.

If you decide to live outside of Canada, you will no longer be covered under this plan. If you live outside Canada and no longer have your provincial health insurance plan in place, you must obtain coverage to replace the provincial health insurance benefits.

Expenses Not Covered

The following expenses are not covered under the Extended Health Plan:

- Hospital accommodation charges in excess of the ward room rate (unless you have elected Semi-Private Hospital coverage).
- Experimental or lifestyle drugs.
- Expenses incurred outside your province of residence if they are required for the emergency treatment of an injury or disease which occurred more than 60 days after the date of departure from the province of residence.
- Expenses for which benefits are payable under a Worker's Compensation Act or similar statute.
- Expenses incurred due to intentionally self-inflicted injuries.
- Expenses incurred due to civil disorder or war, whether or not war was declared.
- Dental expenses, except those specifically provided under eligible expenses for treatment of accidental injuries to natural teeth.
- Expenses for services performed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage.
- Expenses for which benefits are payable under a government plan.
- Expenses for services for which coverage is prohibited by law.
- A portion of expenses for which reimbursement is made due to the legal liability of another party.
- Expenses for services or supplies provided to a patient in a mental hospital, sanitarium or nursing home.
- Cosmetic surgery, plastic surgery or brain or body scanners.
- Rest cures, travel for health, periodic health check-ups or examinations for insurance.

Making a Claim

Your Extended Health policy number is 55410. When making a claim under the Extended Health Plan, please follow the appropriate procedure as listed below:

Pay Direct Drug Benefits

You may use your Allstream/Great-West Life Pay Direct Drug Card to pay for your prescriptions at participating pharmacies. The Policy Number and your member ID are both on the card.

Supplementary Healthcare and Vision Care Benefits

You may obtain a claim form by calling the MTS Allstream Benefits Hotline at 1-800-276-7630. Complete the form in full and mail it, with all original receipts and bills, to Great-West Life at the appropriate address shown on the claim form. Please ensure that you include your pensioner identification number and the policy number on the claim form. All claims must be submitted within 12 months of the date the expense was incurred or such claims will be denied.

Along with every reimbursement, Great-West Life will enclose a claim form which you may use for your next claim.

Out-of-Province Benefits

For 24-hour emergency travel assistance contact Global Medical Assistance immediately when you need medical assistance:

In Canada and USA, call 1-800-527-0218

In Mexico, call 001-800-101-0061

Elsewhere, call collect either:
Baltimore, U.S. (410) 453-6330
or Brighton, England 44-1273-22-3000

Remember to add the long-distance calling code for the USA at the beginning of the (410) number above.

Be ready to state your Provincial Health Card number, policy number and member ID number. You will receive instructions on how to obtain medical assistance.

By calling the 24-hour helpline, Global Medical Assistance will be able to provide you and your insured dependants with the following emergency assistance services during the first 60 days of travel:

1. Physician and hospital referrals
2. On-going monitoring of medical treatment if a family member is hospitalized
3. Coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer a family member to another hospital that is equipped to provide the required treatment
4. Payment assistance for hospital/medical expenses
5. Legal referrals
6. A telephone interpretation service

Eligible claims will be covered by the insurance carrier automatically. To ensure payment of these expenses call the 24-hour helpline immediately. If you are unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Global Medical Assistance travel assistance card **will not** ensure payment of these expenses. If you do not call the 24-hour helpline, you will need to pay the expenses and contact Great-West Life for the appropriate forms. You should submit the following items to Great-West Life:

- all itemized accounts of expenses incurred while outside the province,
- a brief letter indicating the nature of the medical emergency and the date of departure from your province of residence.

Semi-Private Hospital Plan

Semi-Private Hospital coverage is available to all retirees on an optional basis. In the event that you prefer semi-private accommodation where hospitals in your area provide ward as well as semi-private facilities, you may want to consider enrolling in this voluntary program. Check with your local hospital first to see what they provide.

The contribution rates may change from time to time as required by Great-West Life. You may obtain information on current rates by contacting the MTS Allstream Benefits Hotline at 1-800-276-7630.

You may elect this coverage at the time of retirement, or within 31 days of a lifestyle change, without providing medical evidence of insurability. However, if you apply for this coverage later than 31 days from your first day of retirement, or of a lifestyle change, you will be required to provide medical evidence of insurability. Coverage will be granted effective the date Great-West Life approves the evidence of insurability. If medical evidence is not approved, coverage will be declined. This coverage is provided for an unlimited number of days of hospitalization and is not subject to a yearly deductible.

Making a Claim

Generally, the hospital will send your bill directly to Great-West Life. However, if the hospital bills you, you can either pay the bill and submit a claim to Great-West Life, or submit the unpaid bill to Great-West Life and request that they pay the hospital. Please ensure that your pensioner identification number and the policy number are shown on the bill.

Dental Plan

The Dental Plan covers a wide range of dental expenses for you and your eligible dependents. Reimbursements are made on the basis of the Dental Association Fee Guide in effect in your province of residence on the date of treatment.

You must meet a yearly deductible before coverage begins. The yearly deductible is $25 for single coverage, $50 for couple coverage or $65 for family coverage. Routine/major services are limited to a maximum payment of $1,500 per insured person per calendar year. Orthodontic services have a lifetime maximum of $2,000 per eligible child.

Annual deductible	Single: $25 Couple: $50 Family: $65
Eligible expenses: Routine, preventive and minor restorative services	100% of: • Oral examinations • Cleaning and scaling • X-rays • Fillings • Extractions • Periodontia (root canal therapy) • Endodontia (gum treatment)
Major restorative services	50% of: • Crowns • Bridges • Dentures
Orthodontia	50% up to a lifetime maximum of $2,000 (dependent children under age 21 only)
Maximum annual benefit	$1,500 per person (excluding orthodontia)

Preventative and Minor Restorative Services

The Dental Plan pays 100% of the cost of the following preventative and minor restorative services:

- **Routine examinations:** oral examinations, cleaning and scaling of teeth and fluoride applications, each limited to once every six months.
- **X-Rays:** bite-wing x-rays once every six months; full mouth x-rays once every 24 months.
- **Fillings:** amalgam, silicate, acrylic and composite fillings.
- **Extractions:** removal of teeth and alveolectomy at the time of extraction.
- **Oral Surgery:** surgical removal of tumors, cysts, neoplasms, plus the incision and drainage of an abscess, and other necessary dental surgery.
- **Diagnostic Procedures:** x-rays and laboratory tests required in relation to dental surgery.
- **Anesthesia:** general and local anesthesia required in relation to dental surgery.
- **Drugs:** the cost of medication and its administration when provided by injection in the dentist's office.
- **Appliances:** space maintainers for missing primary teeth and habit-breaking appliances.
- **Denture Repairs:** relining and rebasing of existing dentures. Addition of teeth to an existing partial denture if the addition is required to replace one or more teeth extracted while covered under this plan.
- **Periodontia:** treatment of gums and other tissues of the mouth.
- **Endodontia:** treatment of root canals and pulp, including root canal therapy.
- **Consultations:** consultations required between the attending dentist and another dental practitioner.
- **Sealants:** pit and fissure sealants for children under 19 years of age.

Major Restorative Services

The Dental Plan pays for 50% of the cost of the following major restorative services:

- Crowns, inlays and onlays.
- Fixed Bridgework; Partial and Complete Dentures: initial installation to replace natural teeth extracted while covered under the plan.
- Repairs and adjustments to crowns and bridges.
- Examinations: including oral examinations, temporomandibular joint x-rays, diagnostic casts, prosthodontic evaluation.
- Replacement of an existing denture, bridgework, crown, inlay, onlay or periodontal splinting is an eligible expense if the replacement is required to replace an existing denture, bridgework, crown, inlay, onlay or periodontal splinting which was installed at least five years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture, bridgework, crown, inlay, onlay or periodontal splinting.
- The addition of teeth to an existing bridgework is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependent is insured under this plan.

Orthodontic Services

The Dental Plan covers 50% of the cost of services rendered by a licensed orthodontist for your dependent children under age 21, up to a lifetime maximum of $2,000 per child. Treatment plans must be submitted to Great-West Life before any payment will be made.

Expenses Not Covered

The following expenses are not covered under the Dental Plan:

- Expenses for which benefits are payable under a Workers' Compensation Act or a similar statute.
- Expenses incurred due to intentionally self-inflicted injuries.
- Expenses incurred due to civil disorder or war, whether or not war was declared.
- Expenses for which benefits are payable under a government plan.
- A portion of expenses for which reimbursement is made due to the legal liability of another party.
- Broken appointments or the completion of claim forms required by Great-West Life.
- Cosmetic services.
- Initial dentures and bridgework (including crowns and inlays forming the abutments) to replace a tooth or teeth missing before you or your insured dependent became insured under this benefit or to replace a tooth or teeth congenitally missing.
- Crown and onlays, placed on a tooth not functionally impaired by incisal or cuspal damage.
- Replacement of dentures which have been lost, stolen or mislaid.
- Prosthetic devices which are ordered while you or your insured dependent is insured under this benefit but are installed after termination of this benefit.
- Replacement of dentures, bridgework, crowns, inlays, onlays or periodontal splinting and addition of teeth to existing dentures or bridgework except as provided under eligible expenses.
- Replacement of orthodontic appliances which have been lost, stolen, or mislaid.
- Services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for the correction of temporomandibular joint dysfunction (TMJ).

Pre-Determination of Benefits

If a course of dental treatment is expected to cost more than $300, you are advised to have your dentist prepare a description of the treatment which should be submitted to Great-West Life before any work begins. After reviewing the proposed course of treatment, Great-West Life will inform you and your dentist what part of the cost the Dental Plan will pay.

In most cases, the least expensive method of treatment that will provide a professionally adequate result is used as the basis for determining reimbursement.

NOTE:

Any predetermination of benefits is only valid for 6 months from the date of issue.

Making a Claim

Your Dental policy number is 55411. Obtain a dental claim form by calling the MTS Allstream Benefits Hotline at 1-800-276-7630. Complete your portion of the form in full and have your dentist complete the appropriate portion. If your dentist uses a standard provincial claim form, you may use it in place of the Great-West Life form but please be sure to include your policy number and pensioner number for identification purposes. Mail the completed forms to Great-West Life (at the appropriate address shown on the claim form) who will reimburse you or your dentist, as appropriate.

The claim may be submitted to Great-West Life electronically if your dentist has the correct computer software.

All claims must be submitted within 12 months of the date the expense was incurred, or such claims will be denied.

If a member or an insured dependent incurs expenses for the services of a dentist for the treatment of accidental injuries to teeth, payment for these expenses must be made under an extended health insurance policy that includes these expenses as eligible expenses, before the carrier will pay under this provision.

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