

Liquor Control Board of Ontario

Group Policy Number: G0010055A

Plan B: Permanent Full-time Union

Plan C: Permanent Part-time Union

Plan D: Seasonal Employees (Warehouse Facilities) Union

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Group Policy Effective Date: December 1, 2012

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

Your Plan Administrator can answer any questions you may have about your benefits, or how to submit a claim.

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Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for
- Explanation of Common Insurance Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet
- a clear, concise explanation of your Group Benefits
- information you need, and simple instructions, on how to submit a claim

Pay Direct Drug Card

Your Pay Direct Drug Card is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Group Policy Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Group Policy Number and your Certificate Number are also necessary for ALL correspondence with Manulife Financial. Please note that you can print your Certificate Number on the front of this booklet for easy reference.

Your Pay Direct Drug Card is an important document. Please be sure to carry it with you at all times.

Explanation of Common Insurance Terms

The following is an explanation of the terms used in this Benefit Booklet.

Actively at Work

at work for the Policyholder at the employee's usual place of work, and having completed one full day or one full shift.

Benefit Percentage (Co-insurance)

the percentage of covered expenses which is payable by Manulife Financial.

Birth

the complete live delivery of a child from its mother.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Supplementary Health and Hospital Insurance Plan or Dental Care benefit.

Dependent

your spouse or child who is insured under the provincial plan.

-Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

- Child

- your or your spouse's natural or legally adopted child (including the period in which child is living with the adoptive parents during the adoption probation), requires support and is supported solely by the employee, provided the employee is related to the child by blood, by marriage or is the legal guardian, who is:
 - unmarried
 - resides in the same country as the employee
 - not an employee under the group policy
 - is either over 14 days (applicable to Optional Life coverage only), but under age 21, or under age 25 if a full-time student
- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been insured under this Benefit Program immediately prior to that date.

A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support and maintenance, due to a mental or physical handicap.

Manulife Financial may require written proof of the child's condition as medically necessary.

Explanation of Common Insurance Terms

Drug

a medication that has been approved for use by the Federal Government of Canada and has a Drug Identification Number.

Earnings

For Permanent Full-time and Part-time Union (Plans B and C)

for Employee Basic Life, your current hourly rate of pay annualized for regularly scheduled hours of work, exclusive of overtime, bonuses and other compensation

for Long Term Income Protection Plan (LTIP), your hourly rate of pay annualized for regularly scheduled hours of work, exclusive of overtime, bonuses and other compensation, on the date of disability, including any retroactive adjustments which may have an effective date on or prior to the date of disability

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

for Employee Basic Life, your current hourly rate of pay annualized for regularly scheduled hours of work, exclusive of overtime, bonuses and other compensation

for Long Term Income Protection Plan (LTIP), your actual salary received over the 12 month period immediately preceding date of disability, exclusive of overtime, bonuses and other compensation

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Experimental or Investigational

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Gainful Employment

any work:

- for which the employee is qualified, or may become reasonably qualified by education, training or experience; and
- that exists either in the province or territory in Canada where the employee worked when the employee became disabled or where the employee currently lives

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Explanation of Common Insurance Terms

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Medically Necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Non-Evidence Limit

you must submit satisfactory medical evidence to Manulife Financial for Benefit Amounts greater than this amount.

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the insured person lives.

Qualifying Period

a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial,
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

Take Home Pay (Net Earnings)

your earnings, less deductions normally made for federal and provincial income tax.

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workplace Safety and Insurance Act/Loi sur la santé et la sécurité du travail, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Program is provided by the LCBO, underwritten by The Manufacturers Life Insurance Company.

Your Plan Administrator

Your Plan Administrator is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by submitting all required premiums, reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your Plan Administrator with the necessary information to perform such duties.

Your Plan Administrator is _____
Phone Number: _____

Please record the name of your Plan Administrator and the contact number in the space provided.

Applying for Group Insurance Benefits

To apply for Group Benefits, you must submit a completed Group Insurance Application or Change Form, available from your Plan Administrator.

Making Changes

To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you report any changes to your Plan Administrator. Such changes could include:

- change in Dependent Coverage
- change in Beneficiary
- change in Name

To make such changes, you must complete the Group Application or Change Form available from your Plan Administrator.

The Claims Process

Naming a Beneficiary

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Basic Life Insurance and Employee Optional Life Insurance. As a result, you are only permitted to designate a beneficiary for Employee Life and Employee Optional Life. The beneficiary you designate cannot be yourself, nor can you designate a person to receive benefits on your behalf.

How to Submit a Claim

All claim forms, available from your Plan Administrator, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number and your Certificate number (found on your Pay Direct Drug Card) to avoid any unnecessary delays in the processing of your claim.

Your Plan Administrator can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

Alternatively, you can submit your vision, paramedical and dental claims online. As it's all online, there's no paper required and your payment is directly deposited into your bank account, so your money is received much faster. You only need to provide your receipt(s) if asked for them.

How to submit your claims online

1. Login to www.manulife.ca/planmember using your plan contract number, your plan member certificate number and password.
2. Select "**Claims**" from the top navigation, then "**Online Claims**".
3. Follow the simple steps and enter the requested information found on your receipt.

You may not commence legal action against Manulife Financial less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife Financial for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Payment of Supplementary Health and Hospital Insurance Plan and Dental Claims

Once the claim has been processed, Manulife Financial will send a Claim Statement to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, your Plan Administrator will help explain.

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact Manulife Financial Customer Service at 1-800-268-6195.

Co-ordination of Supplementary Health and Hospital Insurance Plan and Dental Care Benefits

If you or your dependents are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs,
- any other arrangement of coverage for individuals in a group, and
- individual travel insurance plans.

Plan does not include school insurance or provincial plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e., responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependent Spouse:

The Plan covering you or your dependent spouse as an employee/member pays benefits before the Plan covering you or your spouse as a dependent.

In situations where you or your spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

- The Plan where the person is covered as an active full-time employee, then
- The Plan where the person is covered as an active part-time employee, then
- The Plan where the person is covered as a retiree.

The Claims Process

- For Claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then
 - The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the dependent child), then
 - The Plan of the parent not having custody of the child, then
 - The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the dependent child).
 - Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
- A claim for accidental injury to natural teeth will be determined under Supplementary Health and Hospital Insurance Plans with accidental dental coverage before it is considered under Dental Plans.
 - If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
 - If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

The Claims Process

The process for submitting a Co-ordination of Benefit claim is as follows:

Claim Belongs to You	You submit the claim to the LCBO insurer first. Any unpaid balance can then be submitted to your spouse's insurer.
Claim Belongs to Your spouse	Your spouse submits the claim to his/her insurer first. Any unpaid balance can then be submitted to your plan for consideration.
Claim Belongs to Your child	Your child's claim should first be submitted to the plan of the parent whose birthday occurs first in the calendar year. (For example, if your birthday is May 1 and your spouse's birthday is December 1, the claim for your child is sent through your plan first). The unpaid balance can then be submitted to the other insurer. If both parents have the same birth date, the plan covering the parent whose name begins with the earlier letter in the alphabet pays first. If you and your spouse are separated or divorced, please note the claims submission requirements outlined above under <i>For Claims incurred by your Dependent Child.</i>

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a full-time, part-time or seasonal employee of LCBO,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

Your dependents are eligible for coverage on the date you become eligible or the date you first acquire a dependent, whichever is later. You must apply for insurance for yourself in order for your dependents to be eligible. If you are applying more than 31 days after becoming eligible for dependent insurance, the insurance becomes effective on the first of the month coinciding with or next following the date of application or approval.

Evidence of Insurability

Medical evidence is required when you apply for insurance in excess of the non-evidence limit.

Medical evidence is also required for all benefits when you make a Late Application for insurance on any person.

Late Application

An application is considered late when you:

- apply for insurance on any person after having been eligible for more than 31 days, or
- re-apply for insurance on any person whose insurance had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you apply for insurance more than 31 days after the date benefits terminated under your spouse's plan.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your Plan Administrator. Further medical evidence may be requested by Manulife Financial.

Effective Date of Coverage

- If Evidence of Insurability is not required, your Group Benefits will be effective on the date you are Eligible.
- If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for insurance to become effective. If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are again actively at work.

Your dependent's insurance becomes effective on the date the dependent becomes eligible, or the date any required medical evidence on the dependent is approved by Manulife Financial, whichever is later.

If you are applying more than 31 days after becoming eligible for dependent insurance, such insurance becomes effective on the first of the month coinciding with or next following the date of application or approval.

Your dependent's insurance will not be effective prior to the date your insurance becomes effective. This does not apply to Dependent Optional Life Insurance which may still become effective if you are declined for Employee Optional Life.

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

- for all benefits other than Employee Optional Life and Dependent Optional Life, the last day of the month in which you cease to be an employee as defined under Eligibility
- for Employee Optional Life and Dependent Optional Life, the date in which you cease to be an employee as defined under Eligibility
- the last day of the month in which termination of your employment occurs
- the date you or your dependent(s) enter the armed forces of any country on a full-time basis
- the date the Group Policy terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age, as shown under each benefit in the Benefit Summary
- the date you are on an approved leave of absence without pay and do not elect to pay the cost of coverage
- the last day of the month coinciding with or next following the date you retire
- the date you cease paying premium, except as provided under the waiver of premium provision for Total Disability
- the date of your death/end of the month of the date of your death for dependent(s)

Your dependents' insurance other than Dependent Optional Life terminates on the last day of the month coinciding with the date of your death, or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Your Group Benefits

Employee Basic Life Insurance

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

Benefit Amount

For Permanent Full-time Union and Seasonal Employees (Warehouse Facilities) Union (Plans B and D)

1 times your annual earnings, to a maximum of \$1,000,000 or a flat amount of \$20,000, whichever is greater, combined for Employee Basic Life Insurance and Employee Optional Life Insurance

For Permanent Part-time Union (Plan C)

1 times your annual earnings, to a maximum of \$1,000,000 or a flat amount of \$10,000, whichever is greater, combined for Employee Basic Life Insurance and Employee Optional Life Insurance

Non-Evidence Limit - \$1,000,000 combined for Employee Basic Life Insurance and Employee Optional Life Insurance

Qualifying Period for Waiver of Premium - 6 continuous months of disability or the expiration of your accumulated attendance credits, whichever is later

Termination Age - your benefit amount terminates on the last day of the month in which you attain age 70 or retirement, whichever is earlier.

Waiting Period

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C)

- First day of the month coincident with or immediately following 2 months of continuous service for employees hired on or prior to the Group Policy Effective Date, and all other employees thereafter.

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

- First day of the month coincident with or immediately following 2 months of continuous service once the employee has reached the eligibility date for benefits of a seasonal employee. The eligibility date is one year from the employee's seasonal anniversary date.

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.

Submitting a Claim

To submit an Employee Basic Life claim, your beneficiary must contact your Plan Administrator who will assist in providing you with the Life Claim form and any other forms that are necessary.

Coverage While Disabled

Employee Basic Life Insurance coverage continues while you are an inactive employee due to Total Disability (as referenced under Definition of Totally Disabled) receiving Long Term Income Protection Plan (LTIP) benefits, and approved for Total Disability waiver of premium by Manulife Financial, up to age 65, or the date you recover from your Total Disability. Your application for waiver of premium is made in conjunction with your application and approval for LTIP.

Should you elect a retirement pension from the Ontario Public Service Employees' Union (OPSEU) Pension Plan while you are Totally Disabled and in receipt of LTIP benefits, your Employee Basic Life Insurance coverage will be reduced.

Definition of Totally Disabled

"Totally Disabled" means that during the qualifying period and the next 24 months of total disability, you are wholly and continuously disabled by illness or accidental bodily injury which prevents you from performing any and every duty of your normal occupation. However, during the qualifying period, you shall be deemed not to be totally disabled and total disability shall be deemed not to exist if you are engaged in any employment for wage or profit. After the qualifying period and the next 24 months of total disability, "Totally Disabled" shall mean you are unable to perform any and every duty of any occupation for which you are reasonably fitted by education, training or experience.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing any and every duty of your normal occupation. However, during the qualifying period, you shall be deemed not to be totally disabled and total disability shall be deemed not to exist if you are engaged in any employment for wage or profit. After the qualifying period and the next 24 months of total disability, "Totally Disabled" shall mean you are unable to perform any and every duty of any occupation for which you are reasonably fitted by education, training or experience.
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing any and every duty of your normal occupation. However, during the qualifying period, you shall be deemed not to be totally disabled and total disability shall be deemed not to exist if you are engaged in any employment for wage or profit. After the qualifying period and the next 24 months of total disability, "Totally Disabled" shall mean you are unable to perform any and every duty of any occupation for which you are reasonably fitted by education, training or experience.

Your Group Benefits

- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial
- the date you do not attend an examination by an examiner
- the date of your death
- the end of the month in which you turn 65

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 3 continuous months of cessation of the Waiver of Premium benefit, Manulife Financial will waive the qualifying period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 3 continuous months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work and completion of at least one full shift.

Conversion Privilege

If your Group Benefits terminate or reduce due to retirement, you may be eligible to convert your Employee Basic Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Employee Basic Life Insurance. If you die during this 31-day period, the amount of Employee Basic Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please contact Manulife Financial at 1-800-268-6195.

Employee Optional Life Insurance

If you die while insured, this benefit provides financial assistance to your beneficiary, in addition to your Employee Basic Life Insurance Benefit. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Benefit Amount - increments of \$10,000 to a maximum of \$350,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of Optional Life Insurance which is \$40,000 or less if applied for within 31 days of the date eligible. If eligible for Optional Life Insurance as both an employee and a spouse, the maximum amount of Employee Optional Life Insurance and Dependent Optional Life Insurance combined is \$350,000.

Qualifying Period for Waiver of Premium - 6 continuous months of disability or the expiration of your accumulated attendance credits, whichever is later

Termination Age - your benefit amount terminates on the last day of the month in which you attain age 65 or retirement, whichever is earlier.

Waiting Period

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C)

- First day of the month coincident with or immediately following 2 months of continuous service for employees hired on or prior to the Group Policy Effective Date, and all other employees thereafter.

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

- First day of the month coincident with or immediately following 2 months of continuous service once the employee has reached the eligibility date for benefits of a seasonal employee. The eligibility date is one year from the employee's seasonal anniversary date.

For Employees in all Plans

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from your Plan Administrator.

For details on **Naming a Beneficiary**, **Submitting a Claim** and **Conversion Privilege**, please refer to Employee Basic Life Insurance.

Coverage While Disabled - Waiver of Premium

If you become Totally Disabled (as referenced under Definition of Totally Disabled) prior to your 65th birthday and are approved for Long Term Income Protection Plan (LTIP) benefits, your Dependent Optional Life Insurance coverage for your spouse will be kept in force and the premiums payable by you on this insurance will be waived until the earliest of the date you cease to be Totally Disabled, retire, you or your spouse become 65 years of age or die.

If you become Totally Disabled (as referenced under Definition of Totally Disabled) prior to your 65th birthday and are approved for Long Term Income Protection Plan (LTIP) benefits, your Dependent Optional Life Insurance coverage for your child/children will be kept in force and the premiums payable by you on this insurance will be waived until the earliest of the date you cease to be Totally Disabled, retire, you become 65 years of age, die, or your dependent child/children no longer meets the definition of an eligible dependent.

Proof of Total Disability satisfactory to Manulife Financial will be required from time to time. Failure to supply such proof may result in the cancellation of your insurance.

Exclusions

If death is the result of suicide and occurs within 2 years after the employee became insured for an initial and/or increased amount of insurance, Manulife Financial liability in respect of such initial and/or increased amount of insurance shall be limited to the amount of premiums paid therefor.

Dependent Optional Life Insurance

If one of your dependents dies while insured, the amount of this benefit will be paid to you.

The Benefit

Benefit Amount

- Spouse - increments of \$10,000 to a maximum of \$200,000
- Child - increments of \$1,000 to a maximum of \$5,000. If both parents are employees, the child can be covered for up to \$5,000 per parent.

Non-Evidence Limit - All amounts of Spousal Optional Life are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of Spousal Optional Life Insurance equal to \$10,000 if applied for within 31 days of the date eligible. Evidence of Insurability is not required for Child Optional Life Insurance.

Termination Age

Spouse - last day of the month coincident with or immediately following the employee's or spouse's attainment of age 65 or employee's retirement, whichever is earlier

Child - last day of the month coincident with or immediately following the employee's attainment of age 65, retirement or the date that your child ceases to be an eligible dependent, whichever is earlier

Waiting Period

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C)

- First day of the month coincident with or immediately following 2 months of continuous service for employees hired on or prior to the Group Policy Effective Date, and all other employees thereafter.

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

- First day of the month coincident with or immediately following 2 months of continuous service once the employee has reached the eligibility date for benefits of a seasonal employee. The eligibility date is one year from the employee's seasonal anniversary date.

For Employees in all Plans

To apply for Dependent Optional Life Insurance you must complete the Application for Optional Life form which is available from your Plan Administrator.

Submitting a Claim

To submit a Dependent Optional Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form should be submitted within 24 months from the date of loss, however payment of the claim will not be made until all supporting information has been filed and verified.

Coverage While Disabled - Waiver of Premium

If you become Totally Disabled (as referenced under Definition of Totally Disabled) prior to your 65th birthday and are approved for Long Term Income Protection Plan (LTIP) benefits, your Dependent Optional Life Insurance coverage for your spouse will be kept in force and the premiums payable by you on this insurance *will be waived* until the earliest of the date you cease to be Totally Disabled, retire, you or your spouse become 65 years of age, or die.

If you become Totally Disabled (as referenced under Definition of Totally Disabled) prior to your 65th birthday and are approved for Long Term Income Protection Plan (LTIP) benefits, your Dependent Optional Life Insurance coverage for your child/children will be kept in force and the premiums payable by you on this insurance *will be waived* until the earliest of the date you cease to be Totally Disabled, retire, you become 65 years of age, die, or your dependent child/children no longer meets the definition of an eligible dependent.

Proof of Total Disability satisfactory to Manulife Financial will be required from time to time. Failure to supply such proof may result in the cancellation of your insurance.

Conversion Privilege

For more information on the conversion privilege, please refer to Employee Basic Life Insurance.

Exclusions

If death is the result of suicide and occurs within 2 years after the employee became insured for an initial and/or increased amount of insurance, Manulife Financial liability in respect of such initial and/or increased amount of insurance shall be limited to the amount of premiums paid therefor.

Supplementary Health and Hospital Insurance Plan

If you or your dependents incur charges for any of the covered expenses specified, your Supplementary Health and Hospital Insurance Plan benefit can provide financial assistance.

Payment of covered expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under covered expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Benefit Percentage, and any other applicable provisions.

Drug Benefit for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance legislation (An Act Respecting Prescription Drug Insurance And Amending Various Legislative Provisions). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit For Persons Who Reside In Quebec, will apply to your drug benefit.

The Benefit

Overall Benefit Maximum – Unlimited

Drug Dispensing Fee Maximum – \$8.00 per prescription

Your Group Benefits

Benefit Percentage (Co-insurance)

For Permanent Full-time Union and Seasonal Employees (Warehouse Facilities) Union (Plans B and D)

100% for

- Hospital Care
- Drugs – when prescribed for Human Chorionic Gonadotropin (HCG) for treatment of anti-obesity, intrauterine devices and diaphragms
- Vision
- Professional Services
- Medical Services and Supplies (other than Orthopaedic Shoes which do not form part of a brace, wheelchair repairs, accessories, modifications, batteries and Other Supplies as noted)
- Drugs – Insulin syringes and testing supplies

90% for

- Drugs – all other eligible prescription drugs
- Drugs – when prescribed for Human Chorionic Gonadotropin (HCG) for treatment of infertility

75% for

- Medical Services and Supplies (Orthopaedic Shoes which do not form part of a brace)

50% for

- Medical Services and Supplies (wheelchair repairs, accessories, modifications and batteries)
- Transcutaneous Nerve Stimulator (TENS)
- Medi-Jectors, Preci-jets, Insulin Infusion Pumps and Supplies

For Example:

If a claim is submitted for services of a registered massage therapist, the claim will be paid at 100% of the reasonable and customary amount, up to the specified per visit maximum and benefit maximum. Therefore, a claim submitted for \$40 for services of a registered massage therapist would be paid in the amount of \$35 and would accumulate towards the overall combined professional services maximum of \$2,000 per calendar year (100% up to the per visit maximum of \$35).

Note:

The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.

For Permanent Part-time Union (Plan C)

You may elect Option 1, Option 2 or Option 3

Option 1

100% for

- Hospital Care
- Drugs – when prescribed for Human Chorionic Gonadotropin (HCG) for treatment of anti-obesity, intrauterine devices and diaphragms
- Vision
- Professional Services
- Medical Services and Supplies (other than Orthopaedic Shoes which do not form part of a brace, wheelchair repairs, accessories, modifications, batteries and Other Supplies as noted)
- Drugs – Insulin syringes and testing supplies

Your Group Benefits

90% for

- Drugs – all eligible prescription drugs
- Drugs – when prescribed for Human Chorionic Gonadotropin (HCG) for treatment of infertility

75% for

- Medical Services and Supplies (Orthopaedic Shoes which do not form part of a brace)

50% for

- Medical Services and Supplies (wheelchair repairs, accessories, modifications and batteries)
- Transcutaneous Nerve Stimulator (TENS)
- Medi-Jectors, Preci-jets, Insulin Infusion Pumps and Supplies

Note:

The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.

Option 2

100% for

- Hospital Care
- Drugs – when prescribed for Human Chorionic Gonadotropin (HCG) for treatment of anti-obesity, intrauterine devices and diaphragms
- Professional Services
- Medical Services and Supplies (other than Orthopaedic Shoes which do not form part of a brace, wheelchair repairs, accessories, modifications, batteries and Other Supplies as noted)
- Drugs – Insulin syringes and testing supplies

90% for

- Drugs – all eligible prescription drugs
- Drugs – when prescribed for Human Chorionic Gonadotropin (HCG) for treatment of infertility

75% for

- Medical Services and Supplies (Orthopaedic Shoes which do not form part of a brace)

50% for

- Medical Services and Supplies (wheelchair repairs, accessories, modifications and batteries)
- Transcutaneous Nerve Stimulator (TENS)
- Medi-Jectors, Preci-jets, Insulin Infusion Pumps and Supplies

Note:

The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.

Option 3

100% for

- Vision
- Medical Services and Supplies (Hearing Aids only)

Termination Age – last day of the month coincident with or immediately following the date in which the employee retires

Your Group Benefits

Waiting Period

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C)

- First day of the month coincident with or immediately following 2 months of continuous service for employees hired on or prior to the Group Policy Effective Date, and all other employees thereafter.

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

- First day of the month coincident with or immediately following 2 months of continuous service once the employee has reached the eligibility date for benefits of a seasonal employee. The eligibility date is one year from the employee's seasonal anniversary date.

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial, provided they are:

- medically necessary and recommended by a physician or surgeon
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the provincial plan or any other government-sponsored program
- legally insurable

In the event that a provincial plan or government-sponsored program or plan or legally mandated program discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

Ontario Assistive Devices Program (ADP)

Where applicable, for many durable and medical equipment application for coverage under the Ontario Assistive Devices Program (ADP) must be made before benefits under the LCBO Supplementary Health and Hospital Insurance Plan are payable. For more information, please call ADP.

ADP covers 75% of many devices including hearing aids, prosthetic devices, respiratory equipment, and ostomy, incontinence and diabetic supplies.

Advance Supply Limitation

Payment of any covered expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

- Drug Expenses

The maximum quantity of drugs that will be payable for each prescription will be limited to the quantity prescribed by your physician, surgeon or dentist.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician, surgeon and pharmacist.

Hospital Care

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C) (Option 1 and Option 2) and Seasonal Employees (Warehouse Facilities) Union (Plan D). Not applicable to Permanent Part-time Union (Plan C) (Option 3).

- charges, in excess of the hospital's public ward charge, for semi-private or private accommodation, up to a maximum of \$170 per day provided:
 - the person was confined to hospital on an in-patient basis, and
 - the accommodation was specifically elected in writing by the patient
- private accommodation for confinement in a chronic care facility up to a maximum of \$25 per day. For those aged 65 and over, subject to a maximum of 120 days in any calendar year.
- semi-private or private accommodation in an alcohol or substance abuse treatment facility (alcohol and substance abuse facilities), up to a maximum of \$170 per day.
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

ManuScript Generic Drug Plan 2 - Prescription Drugs

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C) (Option 1 and Option 2) and Seasonal Employees (Warehouse Facilities) Union (Plan D). Not applicable to Permanent Part-time Union (Plan C) (Option 3).

Charges incurred for the following expenses are payable when prescribed by a physician, surgeon or dentist and dispensed by a licensed pharmacist.

- medically necessary drugs, which by law or convention require the prescription of a physician, surgeon or dentist
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications (charges made by a practitioner, surgeon or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected), including but not limited to Hepatitis A and/or B, influenza, meningitis, chicken pox and allergy serums.
- anti-obesity drugs including Human Chorionic Gonadotropin (HCG)
- fertility drugs including Human Chorionic Gonadotropin (HCG)
- vitamin B6 and B12 for weight loss
- sclerotherapy
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs and rubbing alcohol are not covered)
- viscosupplementation.

Your Group Benefits

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home
- oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions except where federal or provincial law requires a prescription for their sale

- Drug Maximums

Anti-smoking drugs – \$500 per lifetime

Anti-obesity drugs – \$2.00 per injection for Human Chorionic Gonadotropin

Drugs used in the treatment of an erectile dysfunction – \$1,000 per calendar year for oral drugs and \$1,000 per calendar year for invasive drugs

All other covered drug expenses – Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Dispensing Fee Maximum and the Co-insurance.

Covered expenses for any prescribed drug will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

If there is no generic equivalent product for the prescribed drug, the amount covered is the cost of the prescribed product.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician, surgeon or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a "no substitution prescription", please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Manulife Financial for payment.

Payment of your covered drug expenses will be subject to any Drug Dispensing Fee Maximum and the Co-insurance.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C) (Option 1 and Option 3) and Seasonal Employees (Warehouse Facilities) Union (Plan D). Not applicable to Permanent Part-time Union (Plan C) (Option 2).

- eye exams performed by ophthalmologist or optometrist, once in any 24 consecutive months, up to \$80 per person
- purchase and fitting of prescription glasses or elective contact lenses as well as laser surgery performed by an ophthalmologist to “correct vision”, to a maximum of \$300 in any 24 months. If prescription glasses are required due to accidental injury, up to a maximum of one pair (the 24 month and dollar maximum do not apply).
- purchase of prescription glasses and/or contact lenses following cataract surgery, to a maximum of \$50 per eye

Professional Services

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C) (Option 1 and Option 2) and Seasonal Employees (Warehouse Facilities) Union (Plan D). Not applicable to Permanent Part-time Union (Plan C) (Option 3).

- Services provided by a chiropractor, osteopath, podiatrist/chiropractist, massage therapist, naturopath, speech therapist, physiotherapist/athletic therapist and acupuncturist, to a maximum of \$35 per visit up to a combined maximum of \$2,000 per calendar year. Charges for x-rays are not eligible. Charges for surgery in a podiatrist/chiropractist office are covered up to a maximum of \$160 in any calendar year.
- Charges for out-of-hospital services of a psychologist/social worker/master of social work, including family or group therapy, for mental or emotional illness, up to the following maximums:
 - for the initial visit, \$50 per half hour per eligible family member;
 - for each subsequent visit:
 - o for the purposes of psychotherapy and/or testing, \$50 per half hour per eligible family member; or
 - o for the purposes other than psychotherapy and/or testing, \$35 per visit per eligible family member.

Your Group Benefits

Expenses for some of these Professional Services may be payable in part by provincial plans. Coverage for the balance of such expenses prior to reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the provincial plan's maximum for the benefit year has been paid.

Recommendation by a physician or surgeon for Professional Services is not required.

Medical Services and Supplies

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C) (Option 1 and Option 2) and Seasonal Employees (Warehouse Facilities) Union (Plan D). For Employees in Permanent Part-time Union (Plan C) (Option 3) for Hearing Aids only.

For all medical equipment and supplies covered under this provision, covered expenses will be limited to the cost of the device or item that adequately meets the patient's medical needs.

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

- a registered nurse, or
- a registered nursing assistant, licensed practical nurse (or equivalent designation) who has completed an approved medications training program

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available

Medical Equipment

- rental or, when approved by Manulife Financial, purchase of:
 - Mobility Equipment: crutches, canes, walkers, and wheelchairs. Charges for repairs, accessories, modifications and batteries for wheelchairs will be limited to \$500 for any one repair, accessory, modification or battery.
 - Durable Medical Equipment: manual/standard hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses, Supports and Hearing Aids

Please refer to Benefit Percentage (Co-insurance) section for reimbursement levels

- external prostheses
- surgical stockings (compression/support hose), up to a maximum of 2 pairs per calendar year
- surgical brassieres, up to a maximum of 2 per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes:
 - stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes which are specifically modified for you or your eligible dependents (prescription by either a physician, podiatrist/chiropract or surgeon is required). Only certain adjustments/modifications qualify for reimbursement. Please contact Manulife Financial prior to your purchase(s)
 - custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist)
 - shoes attached to or form part of a brace
 - up to a maximum of 3 pairs per calendar year
- casted, custom-made orthotics, up to a maximum of 1 pair per calendar year (a prescription of either a physician, surgeon, chiropractor or podiatrist/chiropract is required)
- ready-made orthotics, limited to dependent children only
- for Permanent Full-time Union and Permanent Part-time Union (Plans B and C) (Option 1 and Option 3) only, cost, installation and maintenance of hearing aids, to a maximum of \$2,500 (\$1,250 per year) in any 36 month period (excluding batteries and repairs) for persons over the age of 10. Unlimited coverage for persons under the age of 10, or if the initial hearing aid is required due to accidental injury.
- stump socks, up to a maximum of 6 pairs per calendar year

Your Group Benefits

Other Supplies and Services

- catheters, ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of chemotherapy, up to a maximum of 2 per calendar year to a maximum of \$100 per wig or hairpiece
- oxygen and oxygen administration
- transcutaneous nerve stimulator (TENS), up to a maximum of \$500 per person per lifetime, payable at 50% co-insurance
- medi-jectors, insulin infusion pumps and supplies and preci-jets, up to a maximum of \$1,000 in any 60 consecutive months, payable at 50% co-insurance
- blood glucose monitoring and bloodletting devices, up to a maximum of \$300 per lifetime
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec. Charges for PSA tests are eligible in all provinces.
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 18 months of the accident
- touch vacuum constrictor, up to a maximum of \$500 per person per lifetime

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the provincial plan during the absence from the province of residence. Expenses are unlimited (physician or surgeon fees subject to Ontario Medical Association Fee Schedule).

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of their province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

Stable means that, in the 90 days before departure, the covered person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician or surgeon feels that, based on the medical evidence, a patient is stable enough to return to his/her home province or territory.

Charges for the following are payable under this expense:

- physician's or surgeon's services, not to exceed 100% of the schedule for fees of the Medical Association of the Province of Ontario
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable if this Benefit covers Hospital Services in Canada. In such case, the amount payable under this expense is subject to the Hospital maximum shown under Supplementary Health and Hospital Insurance Plan.
- the cost of special medical services and supplies
- hospital charges for out-patient treatment
- drugs
- diagnostic x-ray and laboratory services
- paramedical services provided during a covered hospital confinement
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides, including coverage for an escort such as a registered nurse when medically necessary

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the provincial plan.

Charges incurred outside the province of residence for all other Covered Supplementary Health and Hospital Insurance Plan Expenses are payable on the same basis as if they were incurred in the province of residence.

Business Travel Coverage

For an employee who is travelling on company business, expenses incurred outside of Canada for services and supplies directly related to a medical emergency, shall be payable at 100%.

The amount payable for these expenses will be charges less the amount payable by the provincial plan.

Submitting a Claim

To submit a Supplementary Health and Hospital Insurance Plan claim, you must complete a Supplementary Health and Hospital Insurance Plan Claim form, except when claiming for physician, surgeon or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from the Manulife Plan Member Secure Site.

Your Group Benefits

All applicable receipts must be attached to the completed claim form when submitting it to Manulife Financial.

All claims must be submitted within the end of the calendar year following the year in which the claim was incurred. However, upon termination of your insurance, all claims must be submitted within 90 days from the date of termination of insurance.

Claims for Out-of-Canada expenses must first be submitted to the provincial plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the provincial plan.

Alternatively, you can submit your vision and paramedical claims online. As it's all online, there's no paper required and your payment is directly deposited into your bank account, so your money is received much faster. You only need to provide your receipts if asked for them.

How to submit your claims online

1. Login to www.manulife.ca/planmember using your plan contract number, your plan member certificate number and password.
2. Select "**Claims**" from the top navigation, then "**Online Claims**".
3. Follow the simple steps and enter the requested information found on your receipt.

Coverage while Disabled

If you are a permanent full-time or eligible seasonal employee, the LCBO will continue your Supplementary Health and Hospital Insurance Plan and Dental Plan coverage at no cost to you while you are an inactive employee due to Total Disability (as referenced under Definition of Totally Disabled) and provided you are receiving benefits under the Long Term Income Protection Plan (LTIP). Permanent part-time employees must continue to pay for their portion of the premium costs in order to keep coverage in force.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, Manulife Financial may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the payments you received from Manulife Financial, exceed 100% of your incurred expenses.

Exclusions

No Supplementary Health and Hospital Insurance Plan benefits are payable for expenses related to:

- service, including part-time or temporary service in the armed forces of any country
- war (declared or undeclared), insurrection or participation in a riot
- organ transplant once \$25,000 of benefits have been paid in respect of such transplant
- medical or surgical care which is cosmetic
- nursing services other than those prescribed by a physician or surgeon and provided by a graduate registered nurse, RPN, or LPN in the employee's home

- hospital confinement or services and supplies covered under a government hospital or health plan or any other government plan, including any plan in which the employee or dependent is eligible to participate
- charges by a physician, surgeon or dentist for travelling time, broken appointments, room rental or advice given by telephone or other means of telecommunication
- services or supplies, or hospital confinement when there would have been no charge at all in the absence of insurance
- services or supplies, or hospital confinement in a hospital owned or operated by the Government of Canada or the United States, unless the covered person is required to pay for such services regardless of the existence of insurance
- services or supplies, or hospital confinement which are received from a medical or dental department maintained by an employer, association or trade union, trustee or similar group
- services or supplies, or hospital confinement are legally prohibited from coverage
- services or supplies, or hospital confinement which are required for recreation or sports but which are not medically necessary for regular activities
- services or supplies, or hospital confinement which are provided while confined in a convalescent hospital or chronic care facility which is primarily for custodial care
- services or supplies, or hospital confinement which are not a covered expense under this benefit
- delivery and transportation charges
- any hospital confinement, services or supplies related to an accidental bodily injury arising out of or in the course of any employment for remuneration or profit
- any hospital confinement, services, or supplies related to sickness or injury for which you or your dependents are covered by Workplace Safety and Insurance Board or similar program

Drug Benefit For Persons Who Reside In Quebec

If you and your dependents reside in Quebec, the following provisions apply to your drug benefit coverage.

Covered Drug Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred, and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

Your Group Benefits

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List)

The following provisions apply only to the coverage of drugs that are on the RAMQ List, as legislated by An Act Respecting Prescription Drug Insurance (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) Benefit Percentage

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

- i) For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation
- ii) For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:
 - the benefit percentage stated under The Benefit, and
 - the percentage as set out by the then applicable Legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the portion of covered drug expenses which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%.

Amounts that will be applied to the annual out-of-pocket maximum are:

- i) deductible amounts, and
- ii) the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses paid for your dependent children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) Deductible

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered, and
- ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:

- i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Common Insurance Terms), and
- ii) age 26.

Drug coverage provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

- only drugs that are on the RAMQ List are covered, and
- the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age**

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,
- ii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation
- iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation
- iv) the cost required for the drug coverage is the cost of the Supplementary Health and Hospital Insurance Plan benefit.

Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Your Group Benefits

Dental Care

If you or your dependents require any of the dental services specified under covered expenses, your Dental Care benefit can provide financial assistance.

Payment of covered expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under covered expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the benefit percentage, and any other applicable provisions.

The Benefit

Dental Fee Guide – 2013 Ontario Dental Association Approved Fee Guide for General Practitioners effective July 1, 2013

- effective April 1, 2014 – 2014 ODA Fee Guide
- effective April 1, 2015 – 2015 ODA Fee Guide
- effective April 1, 2016 – 2016 ODA Fee Guide

Benefit Percentage (Co-insurance)

100% for Level I – Basic Services

100% for Level II – Supplementary Basic Services

100% for Level III – Dentures

50% for Level IV – Major Restorative Services

50% for Level V – Orthodontics

Benefit Maximums

\$3,000 per calendar year combined for Level I, Level II, Level III and Level IV per person

\$3,000 per lifetime for Level V per person

Termination Age – last day of the month coincident with or immediately following the date in which the employee retires

Waiting Period

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C)

- First day of the month coincident with or immediately following 2 months of continuous service for employees hired on or prior to the Group Policy Effective Date, and all other employees thereafter.

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

- First day of the month coincident with or immediately following 2 months of continuous service once the employee has reached the eligibility date for benefits of a seasonal employee. The eligibility date is one year from the employee's seasonal anniversary date.

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his/her license, or a denturist working within the scope of his/her license
- are reasonable as determined by Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by Manulife Financial, if the expenses are not listed in the Dental Fee Guide. Specialists' fees are limited to the Dental Fee Guide for General Practitioners shown in the Benefit Schedule, except as follows:
 - services rendered by a denturist shall be limited to the maximum fee level of the denturist's own official fee guide; and
 - services rendered by a licensed orthodontist shall be limited to the maximum fee level for his/her specialty.

Alternate Treatment

Where any two or more courses of treatment would produce professionally adequate results for a given condition, your claim will be paid as if the least expensive course of treatment covered under this benefit were used. Manulife Financial will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I - Basic Services

- complete oral exam, one per 3 consecutive years
- full-mouth x-rays, one per 3 consecutive years
- panoramic x-rays, one per 3 consecutive years
- light scaling
- one unit of polishing (referred to as prophylaxis in Quebec), once every 9 months for anyone age 13 and over and once every 6 months for dependent children under age 13
- recall exams, once every 9 months for anyone age 13 and over and once every 6 months for dependent children under age 13
- bitewing x-rays, once every 6 months
- fluoride treatments
- routine special diagnostic and laboratory procedures
- initial oral hygiene instruction, once per lifetime
- fillings and retentive pins.
- pit and fissure sealants, for dependent children age 6 to 18 only

Your Group Benefits

- pre-fabricated full coverage restorations (metal and plastic)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)
- consultations, anaesthesia, and conscious sedation
- injection of antibiotic drugs when administered by a dentist in conjunction with dental surgery
- stainless steel and plastic crowns, once every 5 years
- caries, trauma and pain control
- interproximal discing of teeth
- microbiological test/analysis for the determination of pathological agents
- commercial laboratory procedures

Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - scaling not covered under Level I, and root planing
 - provisional splinting
 - occlusal equilibration, up to a maximum of 8 units per 12 months
- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
- gingival curettage

Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:
 - a natural tooth is extracted (fracture or loss) and the existing appliance cannot be made serviceable
 - the existing appliance is at least 36 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with permanent dentures.
- replacement denture required as the result of an initial placement of an opposing denture, installed after the date the employee became insured under this Dental Care Expense Benefits Provision in respect of the person requiring the replacement denture.

- replacement denture required as the result of an accidental dental injury which occurred after the employee became insured under the Dental Care expenses benefits provision in respect of the person requiring the replacement denture
- denture repairs and additions, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- denture relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture. In addition, charges for prophylactic polishing are also covered.
- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level IV - Major Restorative Services

- crowns and onlays
- inlays
- initial provision of fixed bridgework
- replacement of bridgework , provided the new bridgework is required because:
 - a natural tooth is extracted, fractured or lost and the existing appliance cannot be made serviceable. If the existing bridgework could have been made serviceable, only the expense for that portion of the replacement bridgework which replaces the extracted teeth shall be covered.
 - the existing appliance is at least 36 months old and cannot be made serviceable, or
 - the existing appliance is temporary and is replaced with the permanent bridge.
 - the replacement bridgework is required as the result of an initial placement of an opposing denture, installed after the date the employee became insured under the Dental Care expenses benefits provision in respect of the person requiring the replacement bridgework
 - the replacement of bridgework is made necessary as the result of an accidental dental injury which occurred after the employee became insured under this Dental Care expense benefits provision in respect of the person requiring the replacement bridgework
- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level V - Orthodontics

- orthodontic appliances
- orthodontic casts
- space maintainers
- miscellaneous orthodontic services

Your Group Benefits

- orthodontic services for dependent children only in respect of a dependent child who has attained his/her 6th birthday but not his/her 19th birthday on the date the treatment commenced
- the portion of orthodontic treatment rendered after but which is part of a course of treatment that commenced before the date the employee became insured in respect of the person requiring the orthodontic treatment. It is provided, however, that Manulife Financial shall consider as covered expenses (subject to the definition of “reasonable and customary”) that portion of the expense which is not covered under any other Group Policy.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed \$300, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

If a person's insurance terminates under this Policy as a result of termination of this Policy or this Dental Care Benefit, and an employee or dependent receives treatment for an accidental injury that occurred prior to the date of termination, Manulife Financial will pay for expenses related to such treatment provided the injury is reported to Manulife Financial within the prescribed time pursuant to the Accident and Sickness Insurance Act of the employee's province of residence.

If a person's insurance terminates under this Policy for reasons other than termination of this Policy or this Dental Care Benefit, and endodontic treatment had begun exposing a tooth, Manulife Financial will pay for expenses related to such treatment provided the expense is incurred within 31 days after the plan benefits terminate.

If a person's insurance terminates under this Policy for reasons other than termination of this Policy or this Dental Care benefit, and a course of orthodontic treatment had commenced for which Manulife Financial had paid benefits prior to the termination, Manulife Financial will pay for expenses related to the course of treatment but not exceeding the amount that would have been paid in the 3-month period immediately following the termination date had plan benefits not terminated.

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available from your employer.

All claims must be submitted within the end of the calendar year following the year in which the claim was incurred. However, upon termination of your insurance, all claims must be submitted within the earlier of 12 months from the date the expense was incurred or 90 days from the date of termination of insurance.

Alternatively, you can submit your dental claims online. As it's all online, there's no paper required and your payment is directly deposited into your bank account, so your money is received much faster. You only need to provide your receipts if asked for them.

How to submit your claims online

1. Login to www.manulife.ca/planmember using your plan contract number, your plan member certificate number and password.
2. Select “**Claims**” from the top navigation, then “**Online Claims**”.
3. Follow the simple steps and enter the requested information found on your receipt.

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, Manulife Financial may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the payments you received from Manulife Financial, exceed 100% of your incurred expenses.

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- charges for broken appointments or completion of claim forms
- which are not a covered expense under this benefit
- treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction
- the replacement of removable appliances which are lost, mislaid or stolen
- services and supplies rendered for dietary planning for the control of dental caries or for plaque control
- services and supplies rendered for the correction of any congenital or developmental malformation which is not a Class I, Class II or Class III malocclusion
- dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature
- charges by a physician, surgeon, dentist or dental hygienist for traveling time, broken appointments, transportation costs, room rental or advice given by telephone, or other means of telecommunication
- implants, or any services rendered in conjunction with implants. However, where an implant is the choice of treatment and a denture or bridge would produce professionally adequate results for the condition, Manulife Financial will pay the cost of the implant expense and any related services, at a cost equal to the least expensive cost of a denture or bridge
- services for which you or your dependents are covered under the Workplace Safety and Insurance Board (WSIB) or a similar program that will be first payor.

Long Term Income Protection

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Manulife Financial will pay a disability benefit.

Definition of Totally Disabled

"Totally Disabled" means that during the qualifying period and the next 24 months of total disability, you are wholly and continuously disabled by illness or accidental bodily injury which prevents you from performing any and every duty of your normal occupation. However, during the qualifying period, you shall be deemed not to be totally disabled and total disability shall be deemed not to exist if you are engaged in any employment for wage or profit. After the qualifying period and the next 24 months of total disability, "Totally Disabled" shall mean you are unable to perform any and every duty of any occupation for which you are reasonably fitted by education, training or experience.

The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

The Benefit

Benefit Amount - 66.67% of gross monthly earnings

Qualifying Period - 6 continuous months of disability or the expiration of the employee's accumulated attendance credits, whichever is later

- Benefits are payable from the end of the qualifying period. Benefits are not payable for or during the qualifying period.
- You must be receiving regular, ongoing care and treatment from a physician during the qualifying period in order for benefits to be payable at the end of the qualifying period.

Maximum Benefit Period - last day of the month in which the employee attains age 65

Termination Age - age 65 less the qualifying period, or retirement, whichever is earlier

Waiting Period

For Permanent Full-time Union and Permanent Part-time Union (Plans B and C)

- First day of the month coincident with or immediately following 2 months of continuous service for employees hired on or prior to the Group Policy Effective Date, and all other employees thereafter.

For Seasonal Employees (Warehouse Facilities) Union (Plan D)

- First day of the month coincident with or immediately following 2 months of continuous service once the employee has reached the eligibility date for benefits of a seasonal employee. The eligibility date is one year from the employee's seasonal anniversary date.

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing any and every duty of your normal occupation. However, during the qualifying period, you shall be deemed not to be totally disabled and total disability shall be deemed not to exist if you are engaged in any employment for wage or profit. After the qualifying period and the next 24 months of total disability, "Totally Disabled" shall mean you are unable to perform any and every duty of any occupation for which you are reasonably fitted by education, training or experience.
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner.

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

- not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial
- receiving Employment Insurance maternity or parental benefits
- on lay-off during which you become Totally Disabled if you ceased to continue coverage on a premium paying basis during the period of Temporary Lay-off
- receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan
- working in any occupation, except as provided for under the Rehabilitation Assistance provision

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive:

- from the following sources for the same or related disability:
 - Workers' Compensation or similar coverage
 - Canada or Quebec Pension Plans, excluding dependent benefits
 - any retirement benefit or disability benefits provided by the employer
- from either of the following sources:
 - any government motor vehicle automobile insurance plan or policy, unless prohibited by law
 - 50% of the employee's rehabilitation income

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 100% of your pre-disability gross earnings.

Your Group Benefits

Benefit Calculation Rules

Manulife Financial will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current Disability will not be taken into account
- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife Financial
- subsequent changes in benefits to the initial CPP or QPP award may be taken into consideration and a new benefit amount may be established, subject to review with the Policyholder. If you do not apply for CPP/QPP disability benefits for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid
- benefits payable under individual disability income insurance will not be taken into account
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid (i.e., Canada or Quebec Pension Plan offsets)
- an estimate of the amount of any government award will be used prior to the advice of the actual award.

Subrogation

Subrogation is the right to recover replacement income received from a third party. For example, if you are injured on public or private property and take legal action to recover damages for loss of income, Manulife Financial could make a claim against any money awarded for your loss of income.

If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial will request that you complete a subrogation reimbursement agreement when you submit your Long Term Income Protection (LTIP) claim.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.

Tax Status

Any Long Term Income Protection (LTIP) benefits received from Manulife Financial are taxable.

Payment of Disability Benefits

Disability benefit payments will be made monthly. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.

Rehabilitation Assistance

Once Manulife Financial determines that you are Totally Disabled, if appropriate, and at Manulife Financial's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation. Rehabilitation assistance cannot exceed 24 months.

In considering whether Rehabilitation Assistance is appropriate for you, Manulife Financial will take into account:

- the nature, extent and expected duration of your disability
- your level of education, training or experience
- the nature, scope, objectives and cost of a vocational plan

- Vocational Plan

A vocational plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife Financial will provide a structured vocational plan that will prepare you for a return to work, either:

- with your employer
- with an alternate employer
- in a self-employed capacity (if initiated by the claimant and deemed appropriate)

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the vocational plan. Your Disability Benefit will be reduced by 50% of your rehabilitation income. If you receive any earnings as part of the plan, your disability benefit will be further reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross earnings.

If you cease to participate in the vocational plan because of a change in your medical status, Manulife Financial will require medical evidence documenting how your current medical status prevents you from continuing with the vocational plan.

If you are not available or do not co-operate or participate in the vocational plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing any and every duty of your normal occupation. However, during the qualifying period, you shall be deemed not to be totally disabled and total disability shall be deemed not to exist if you are engaged in any employment for wage or profit. After the qualifying period and the next 24 months of total disability, "Totally Disabled" shall mean you are unable to perform any and every duty of any occupation for which you are reasonably fitted by education, training or experience.
- the date you do not attend an examination by an examiner
- the date of your death

Your Group Benefits

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 3 consecutive months from the end of the period for which Long Term Income Protection (LTIP) benefits were paid (excluding service during rehabilitative employment), Manulife Financial will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the qualifying period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period (last day of the month in which you attain age 65) for this benefit.

If the same disability recurs more than 3 consecutive months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Waiver of Premium

The premium for your Long Term Income Protection (LTIP) benefit will be waived during any period you are entitled to receive Long Term Income Protection (LTIP) benefit payments.

Submitting a Claim

To submit a claim, you must complete the Long Term Income Protection (LTIP) claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Manulife Financial within one year from date of disability.

Exclusions

No benefits are payable for any disability related to:

- accidental bodily injury or illnesses which is result of war, declared or undeclared
- accidental bodily injury or illnesses which is result of insurrection or participation in a riot or civil commotion, unless the employee was performing the normal duties of his/her occupation and was not disregarding instructions of the employer
- medical or surgical care which is not medically necessary. If disability is not as a result of elective surgery, but as a result of complications, for example acquiring a treatment resistant bacteria while in the hospital, and the claimant is unable to work because of the infection the disability claim would be covered
- the committing of or the attempt to commit an assault or criminal offence
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an appropriate medical treatment program for substance abuse

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of the Liquor Control Board of Ontario. The information in this booklet is a summary of the provisions of the Group Policy. In the event of a discrepancy between this booklet and the Policy, the terms of the Group Policy will apply.

The booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependents are covered. The Group Policy must be in effect and you must satisfy all the requirements of the Policy.

Where required by law, you or any claimant under the Group Policy has the right to request a copy of any or all of the following items:

- the Group Policy,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy.

Manulife Financial reserves the right to charge you for such documentation after your first request.

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

For Your Information

If you have any questions on the benefits described in this booklet or need to obtain forms or other information, please go to www.manulife.ca/groupbenefits, or contact Manulife Financial at 1-800-268-6195.

The Corporate Benefits Services & HR Information Management Department of the LCBO can be reached at:

Human Resources Division
55 Lakeshore Blvd. E., 2nd Floor
Toronto, Ontario M5E 1A4

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.

This image shows a full page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, providing a template for handwriting practice or general writing. There are no margins, text, or other markings on the page.