Toronto Transit Commission

Plan Document Number: 86678B

Group Policy Number: 38763B

Plan B: Unionized Employees (Regular Full-Time)

Employee Name: ____

Certificate Number: ____________________________________

Welcome to Your Group Benefit Program

Plan Document Effective Date: January 1, 2012

Group Policy Effective Date: January 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.

This booklet produced: November 25, 2015

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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 Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits, and
- information you need, and simple instructions, on how to submit a claim.

Important Note

The Toronto Transit Commission (TTC) reserves the right, at any time and in its sole discretion, to change, alter, amend, add to or remove any portion of any benefit plan. The TTC further reserves the right, at its sole discretion, to determine whether to apply the change, alteration, amendment, addition to or removal to the employee survivor benefit plan, the pensioner benefit plan, and the pensioner survivor benefit plan. The TTC will provide to the members of the applicable benefit plan at least 30 days' notice of any change, alteration, amendment, addition to or removal.

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of the TTC. The information in this booklet is a summary of the provisions of the Group Policy for the Employee Life Insurance, Employee Optional Life Insurance and Line of Duty Death Insurance and Accidental Death and Dismemberment, and the Plan Document for the Extended Health Care, Dental Care and Long Term Disability Benefits and the By-Laws of the Sick Benefit Association. In the event of a discrepancy between this booklet and the Policy or Plan Document or By-Laws (both available from the TTC), the terms of the Policy or Plan Document or By-Laws will apply.

The information on all benefits insured or administered by Manulife Financial is up to date as of July 1, 2014.

The Short Term Disability – Sick Benefit Association Plan described in this booklet is self-insured by the TTC. Your Plan Sponsor has provided this wording for use in this booklet and is responsible for ensuring it is accurate, up to date and consistent with the governing policy. Manulife Financial is not responsible for any claims in connection with the booklet wording relating to this benefit. In the event of a discrepancy between this booklet and the policy, the terms of the Sick Benefit Association By-Laws will govern. Manulife Financial shall not be responsible for any detrimental reliance that you may place upon this information whatsoever.

All other benefits are insured or administered by Manulife Financial.

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 and Plan Document must be in effect and you must satisfy all the requirements of the Plan.

How to Use Your Benefit Booklet

You or any of your covered dependents have the right to request a copy of any or all of the following items:

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

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.

This booklet is also available by logging into Manulife Financial's Plan Member Site at www.manulife.ca/groupbenefits, or from your work location or the TTC's Benefit Services, Human Resources Department.

Your Group Benefit Card

Your Group Benefit 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, Plan Document 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, Plan Document 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.

If you require additional Group Benefit Cards for you or your dependents, or need to replace a lost or damaged card, please call Manulife Financial directly at 1-800-268-6195.

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

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

Accident

an unexpected or unforeseen happening or event involving an external force, causing loss or injury, independently of all other causes.

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by the TTC.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by the TTC.

Dependent

your Spouse or Child who is covered 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 who is a resident of Canada.

Only one spouse will be eligible for benefits under this plan, and will be as indicated by the employee on the employee's application for benefits under this plan. Where this information is not contained on the employee's application, the person who qualifies last under this plan's definition of spouse will be the eligible spouse.

Former spouses will be eligible for coverage under this plan, when coverage is mandated by a court order. Only a former spouse covered as a former spouse before March 1, 2001 will be eligible for coverage under this plan.

- Child

- your natural or adopted child, or stepchild, or a child for whom the employee or spouse has been court appointed legal guardian or court appointed legal custody for all purposes by a court of competent jurisdiction, who is:

  - unmarried

  - lives with the employee unless residing elsewhere for the sole purpose of attending a recognized educational institution

  - not employed on a full-time basis and relies on the employee for financial support

  - not covered under this plan as an employee

  - not eligible for coverage as an employee under this or any other Group Benefit Program

- a child to whom the employee is obligated to provide benefit coverage pursuant to a written separation agreement

- a resident of Canada and has health plan coverage under the provincial government plan (or replacement plan)

- under age 21, or under age 25 if a full-time student at an accredited school, college or university. Coverage will continue until the end of the month in which the child turns age 21 or age 25 if a full-time student.

- a child covered under this Benefit Program, who is incapacitated due to a mental or physical disability on the date the child reaches the age when coverage would normally terminate will continue to be an eligible dependent.

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

  The TTC may require written proof of relationship with a child prior to approving benefit coverage. Proof of the student's full-time enrollment in a recognized educational institution is required on or before the child's 21st birthday and every year to the age of 25.

  The TTC may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible

Drug

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

Earnings

your regular rate of pay from the TTC (prior to deductions), excluding regular bonuses, regular overtime pay and regular commissions.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the amount reported on your claim form.

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.

Immediate Family Member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

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.

Life-Sustaining Drugs

drugs which are necessary for the survival of the patient.

Line of Duty

performing any act or thing pertaining to employment with the TTC.

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 covered 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.

Specialist Physician

a doctor who has undergone structured post-graduate training in a specific field of medicine.

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 as required by law and/or statute.

Waiting Period

the period of continuous employment with the TTC 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, Workers' Compensation Act, 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.

How to Contact Manulife Financial and Toronto Transit Commission Representatives

If you cannot find the answer to your question or inquiry in this booklet, we are here to assist. You may contact Manulife Financial's Customer Service Centre at 1-800-268-6195, Monday to Friday, 8am to 8pm. Please have your plan number (listed on the cover page of this booklet) and your certificate number (your employee number) ready. You may also access the Plan Member Site at www.Manulife.ca/groupbenefits for information on your benefit coverage, covered dependents, claims history, claim forms, online claims submission, or use the "Send a Note" function.

You may also contact the TTC if you have specific questions on:

- Extended Health Care, Dental, Group Life or Accidental Death & Dismemberment benefits – call Benefit Services, Human Resources Department at 416-393-2635, 416-393-4370, or toll-free 1-888-268-5694

- Sick Benefit Association or Long Term Disability benefits – call Occupational Health & Claim Management, Human Resources Department at 416-393-4572

- Death benefits application and claims – call the Pension Fund Society at 416-393-4521 or toll-free at 1-800-663-6820

Enrolling for Group Benefits

You will be automatically enrolled for Group Benefits (i.e. Extended Health Care, Dental Care, Basic Life, Line of Duty Death, Accidental Death & Dismemberment, Sick Benefit Association Plan, and Long Term Disability) once the applicable waiting periods have been completed. Prior to your start date, or once you become eligible for benefits, you will be provided with the necessary TTC forms to add your dependents on coverage or to designate life insurance beneficiaries.

Making Changes

The TTC is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Plan, it is your responsibility to provide the TTC with the necessary information to perform such duties.

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

- change in Dependent Coverage that is, to add or remove dependents from your coverage
- change in spousal coordination of benefits information
- change in Beneficiary
- change in name, address or telephone number

To report changes, please use the following TTC forms:

TTC Form #803113 Employee Information Change – To change your name, address and/or telephone number

TTC Form #803114 Healthcare and Dental Coverage/Dependent Change of Information – To add/remove dependents from coverage and update spousal coordination of benefits information

TTC Form #1455 Basic Life Beneficiary Designation Card – To designate a beneficiary or change a beneficiary

TTC Form #1239 Optional Life Beneficiary Designation Card – To enroll for Optional Life Insurance (either once completed the waiting period, or during Annual March Open Period) or to change beneficiary designation

These TTC forms are readily available from your work location.

The Claims Process

Naming a Beneficiary

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Life Insurance, Employee Optional Life Insurance, Line of Duty Death Insurance and Accidental Death and Dismemberment.

How to Submit a Claim

All claim forms are available from:

- your work location,
- online at www.manulife.ca/groupbenefits,
- TTC's Human Resources intranet site, or
- TTC's Benefit Services, Human Resources Department.

Claim forms must be completed correctly, dated and signed. Remember to always provide your Group Plan Contract Number and your Certificate Number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

Claims for Extended Health Care or Dental Care expenses must be complete using an Extended Health Care or Dental Care claim form. Forms and expenses should be sent by regular mail to the Manulife Financial address found on the claim form (no registered mail will be accepted).

All claims forms must be accompanied by the original paid receipt and doctor's recommendation where necessary. Please keep copies of all documentation submitted.

Claims for Emergency Out-of-Canada expenses (e.g. doctor visits or ambulance services only) 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. To submit an Emergency Out-of-Canada claim, you must complete an Out-of-Province/Canada claim form, and mail it to the Manulife Financial address found on the claim form.

If your health care service provider cannot send Manulife electronic claim transmissions, you may still be able to submit your claim electronically to us online, right from the Plan Member Secure Site. Sign up or login to Manulife Financial's Plan Member Secure Site at www.manulife.ca/groupbenefits. It will only take you a few minutes to answer the necessary questions and create your own electronic claim submission. You must retain all paperwork for audits.

Please remember that all claims must be received by Manulife Financial within 90 days from the end of the calendar year in which the expense was incurred (i.e. no later than March 31st).

For life insurance and accidental death & dismemberment claims, please refer to the appropriate section in this benefit booklet for specific information on how to submit a claim.

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

Payment of Extended Health Care 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 deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, Manulife Financial 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.

Co-ordination of Extended Health Care 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.

- 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 Extended Health Care 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.

Eligibility

You are eligible for Group Benefits if you:

- are a regular full-time employee of the TTC and work at least the Required Number of Hours,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada and have health plan coverage under the provincial government plan (or replacement plan), 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 must be a resident of Canada and have health plan coverage under the provincial government plan (or replacement plan). 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 coverage for yourself in order for your dependents to be eligible.

Required Number of Hours

Full-time employee - 40 hour(s) per week

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.
- If medical evidence 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 plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

Your dependent's coverage 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.

Your dependent's coverage will not be effective prior to the date your coverage becomes effective.

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee for reasons other than retirement
- the date you cease to be actively at work, unless the Group Policy or the Plan Document allows for your coverage to be extended beyond this date
- the date the TTC terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

Your dependents' coverage terminates on the date your coverage terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Manulife Financial's Policy *G0038763B.*

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.

The Benefit

Benefit Amount - 2 times your annual earnings

Non-Evidence Limit - none

Premium Cost - 50% co-shared between the TTC and you. Your share of the premium will be deducted automatically from your pay each month.

Qualifying Period for Waiver of Premium - 26 weeks plus exhaustion of Employment Insurance benefits, if applicable, and accumulated vacation, floater days and lieu time

Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier. On retirement, your coverage may continue under the appropriate retiree plan.

Waiting Period - first of the month coincident with or next following 6 months of continuous or cumulative service from the date of hire

Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. Form #1455 Basic Life Beneficiary Designation Card is available from your work location or the TTC's Benefit Services, Human Resources Department. Once completed, this form must be submitted to the TTC's Benefit Services, Human Resources Department.

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

If you do not complete a card to designate a beneficiary, death benefits will be payable to your estate.

Submitting a Claim

To submit an Employee Life Insurance claim, or claim under any other life or Accidental Death and Dismemberment benefit, your beneficiary must complete the Life Claim form which is available from the TTC's Pension Fund Society.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted to Manulife Financial within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form, which is available from the TTC's Benefit Services, Human Resources Department. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Manulife Financial within 90 days from the end of the Qualifying Period.

Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Definition of Totally Disabled

For the qualifying period and the first 24 months immediately following the qualifying period, totally disabled means you are wholly and continuously disabled due to an illness or accidental injury which prevents you from performing any and every duty of your normal occupation.

Thereafter, totally disabled means you are unable to perform any and every duty of any occupation for remuneration or profit with the range of your 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:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 30 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled.

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that:

  - for the qualifying period and the first 24 months immediately following the qualifying period, you are wholly and continuously disabled due to an illness or accidental injury which prevents you from performing any and every duty of your normal occupation, and

  - thereafter, you are unable to perform any and every duty of any occupation for remuneration or profit with the range of your 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 selected by Manulife Financial.

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:

  - for the qualifying period and the first 24 months immediately following the qualifying period, you are wholly and continuously disabled due to an illness or accidental injury which prevents you from performing any and every duty of your normal occupation, and

  - thereafter, you are unable to perform any and every duty of any occupation for remuneration or profit with the range of your education, training or experience

- 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 selected by Manulife Financial
- the date of your death
- the date of your 65th birthday

If your coverage transfers to a retiree division prior to cessation of waiver of premiums, that waiver will also transfer to the retiree policy.

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 6 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 6 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 of at least one full shift.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee 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 Life Insurance. If you die during this 31-day period, the amount of Employee 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, or to obtain a conversion application form, you may contact Manulife Financial. Provincial differences may exist.

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Manulife Financial's Policy *G0038763B.*

If you die while insured, this benefit provides financial assistance to your beneficiary, in addition to your Employee 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 $5,000 to a maximum of $100,000

Premium Cost - 100% paid by you. The premium will be deducted automatically from your pay each month.

Non-Evidence Limit - Evidence of Insurability is required for all amounts of Optional Life Insurance. However, evidence of insurability will be waived for an amount of Optional Life Insurance which is $25,000 or less if applied for within 31 days of the date eligible. Additionally, each March if you were not covered before, you can apply for up to $25,000 without evidence of insurability, and if you were covered before for less than $25,000, you can apply for more coverage without evidence of insurability as long as the existing total coverage is not greater than 25,000.

Qualifying Period for Waiver of Premium - 26 weeks plus exhaustion of Employment Insurance benefits, if applicable, and accumulated vacation, floater days and lieu time

Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier. On retirement your coverage may continue under the appropriate retiree plan.

Waiting Period - first of the month coincident with or next following 6 months of continuous or cumulative service from the date of hire

You may apply for Employee Optional Life Insurance by completing the TTC Form #1239 Optional Life Beneficiary Designation Card within 31 days of completing the required waiting period for Optional Life. Thereafter, you may apply for or increase Optional Life coverage every March during the Annual Open Period Campaign, by completing Form #1239 Optional Life Beneficiary Designation Card. The form is available from your work location or the TTC's Benefit Services, Human Resources Department. Once completed, this form must be submitted to the TTC's Benefit Services, Human Resources Department.

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

Naming a Beneficiary

You have the right to change a beneficiary, subject to governing law, by completing Form #1239 Optional Life Beneficiary Designation Card. The form is available from your work location or the TTC's Benefit Services, Human Resources Department. Once completed, this form must be submitted to the TTC's Benefit Services, Human Resources Department.

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

If you do not complete a card to designate a beneficiary, death benefits will be payable to your estate.

Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Line of Duty Death Insurance Benefit

The Line of Duty Death Insurance Benefit is insured under Manulife Financial's Policy *G0038763B*.

If you die as a result of an accident in the Line of Duty while insured, Manulife Financial will pay the amount of this benefit for which you were insured at the time of your death.

No payment will be made for a death claim which was payable under the Accidental Death and Dismemberment Benefit.

The Benefit

Benefit Amount - 4 times your annual earnings, to a maximum of $2,500,000

Non-Evidence Limit - $2,500,000

Premium Cost - 100% paid by the TTC

Termination Age - your benefit amount terminates upon your retirement
Waiting Period - none

Naming a Beneficiary - The beneficiary of this benefit will be the same as named under Employee Life Insurance.

Submitting a Claim

To submit a Line of Duty Death Claim, your beneficiary must complete a Claim form.

Forms are available from the TTC's Pension Fund Society, and require a physician's statement.

A completed claim form must be submitted to Manulife Financial within 90 days from the date of loss.

Exclusions

No benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of the TTC
- committing or attempting to commit an assault or criminal offence
- a drug overdose
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Manulife Financial's Policy *G0038763B*.

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

The Benefit

Benefit Amount - 2 times your annual earnings, to a maximum of $1,000,000

Premium Cost - 50% co-shared between the TTC and you. Your share of the premium will be deducted automatically from your pay each month.

Qualifying Period for Waiver of Premium - 26 weeks plus exhaustion of Employment Insurance benefits, if applicable, and accumulated vacation, floater days and lieu time

Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier. On retirement your coverage may continue under the appropriate retiree plan.

Waiting Period - first of the month coincident with or next following 6 months of continuous or cumulative service from the date of hire

Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

No payment will be made for a death claim which was payable under the Line of Duty Death Insurance Benefit.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of or Loss of Use of Both Arms or Both Legs - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%

- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 75%
- Loss of Sight of One Eye - 75%
- Loss of Speech or Hearing in Both Ears - 75%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 12%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental Injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife Financial will pay incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses

If you die as a direct result of an accidental injury which occurs while travelling 150 kilometres or more from your place of residence, Manulife Financial will pay for expenses incurred for the preparation and transportation of your body to your place of residence.

The amount payable is subject to a maximum of $10,000.

Family Transportation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and are confined to a hospital located 150 kilometres or more from your place of residence, Manulife Financial will pay the hotel and travel expenses incurred by an immediate family member, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- for hotel accommodations in the vicinity of the hospital
- for transportation by the most direct route to the hospital, including return fare

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of $0.20 per kilometre travelled.

The amount payable is subject to a maximum of $10,000 per accident.

Dependent Education Expenses

If you die as a direct result of an accidental injury, Manulife Financial will pay the tuition for each child who is enrolled as a full-time student:

- in a school for higher learning above the secondary school level, or
- at the secondary school level, but who enrols as a full-time student in a school for higher learning within 365 days after your death.

A school for higher learning means any accredited university, private college, collèges d’enseignement général et professionel (CEGEP), community college or trade school.

The maximum payable each year for each child is the lesser of:

- 5% of your Accidental Death and Dismemberment benefit amount, or
- $5,000

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- tuition expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Spousal Occupational Training Expenses

If you die as a direct result of an accidental injury and your spouse must participate in a formal occupational training program to become qualified for employment for which they would not otherwise have sufficient qualifications, Manulife Financial will pay for expenses incurred by your spouse, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $5,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Day-Care Expenses

If you die as a direct result of an accidental injury, Manulife Financial will pay day-care expenses for each child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 365 days from the date of your death.

The maximum payable each year for each child is the lesser of:

- 5% of your Accidental Death and Dismemberment benefit amount, or
- $5,000

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Home Alteration and Vehicle Modification Expenses

If, as a direct result of an accidental injury, you:

- suffer a loss of, or loss of use of, both feet or both legs, or
- become a hemiplegic, paraplegic, or quadriplegic

and require the use of a wheelchair to be ambulatory, Manulife Financial will pay for incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within 3 years from the date of the accidental injury
- for alterations to your home for the purpose of making it wheelchair accessible
- for modifications to one motor vehicle for the purpose of making it wheelchair accessible

The amount payable is subject to a maximum of $10,000.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Naming a Beneficiary

The beneficiary of this benefit will be the same as named under Employee Life Insurance.

Submitting a Claim

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form, available from the TTC's Pension Fund Society

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form, available from the TTC's Benefit Services, Human Resources Department.

Both forms require a physician's statement.

A completed claim form must be submitted to Manulife Financial within 90 days from the date of loss.

Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

Exclusions

No Accidental Death & Dismemberment benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of the TTC
- committing or attempting to commit an assault or criminal offence

- a drug overdose
- loss of life which occurs while you are performing any act or thing pertaining to your employment with the TTC
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

Extended Health Care

Your Extended Health Care Benefit is provided directly by the TTC. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and the TTC's Benefit Plan.

If you or your dependents incur charges for any of the Covered Expenses specified, your Extended Health 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 Deductible, Benefit Percentage, and any other applicable provisions.

Drug Benefit for Ontario Residents

For active employees age 65 and older, the Ontario Drug Benefit Plan will be the first payer and the TTC plan will be the second payer on your prescription drugs. Drug benefits for dependent spouses terminates when the spouse attains age 65. You may speak to your pharmacist to register you with the Ontario Drug Benefit Plan.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - $10 Individual, $20 Family, per calendar year(s)

Not applicable to:
    Hospital Care
    Drugs
    Out-of-Province/Canada Emergency Medical Treatment

Drug Deductible - $1.00 per prescription

Drug Dispensing Fee Maximum - $9.00 per prescription

Benefit Percentage (Co-insurance)

100% for
    Drugs
    Vision
    Professional Services
    Medical Services and Supplies
    Out-of-Canada Emergency Medical Treatment

50% for
    Hospital Care

Termination Age - end of the month in which you retire. However, coverage for the Drug expense for your spouse shall cease at the end of the month in which your spouse attains age 65, if prior to your retirement. At retirement, if you are covered under the TTC's health plan the day before retirement and eligible for a pension from the TTC, then coverage may continue under the appropriate retiree plan, provided you have 10 or more years of service or 29 years of credited pension service.

- Deductible Carry-Forward

Covered Expenses used to satisfy the deductible in the last 3 months of the calendar year may also be used to satisfy the deductible in the following calendar year.

Waiting Period

first of the month coincident with or next following 6 months of continuous or cumulative service from the date of hire. However, an employee may elect to be covered at the employee's own expense from the first of the month after the date of hire until the end of the waiting period.

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 for the treatment of sickness or injury and recommended by a physician
- 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.

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 lesser of:

a) the quantity prescribed by your physician or dentist, or

b) a 34 day supply.

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 and pharmacist.

ManuScript Generic Drug Plan 2 - Prescription Drugs

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

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives and intrauterine devices
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- administration of injectable drugs
- 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
- diaphragms

- Drug Maximums

Fertility drugs – 6 cycles per lifetime

Anti-smoking drugs - $300 per lifetime

All other covered drug expenses - Unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to the Drug Deductible and Dispensing Fee Maximum.

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 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 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

To receive reimbursement after paying the full cost of the prescription, please submit a claim form to Manulife Financial, or refer to the section on “How to Submit a Claim”.

Hospital Care

- charges, in excess of the hospital's public ward charge, for semi-private accommodation up to a maximum of $125 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

- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Vision Care

- eye exams, $450 per any 24 consecutive months, combined for eye exams and prescription glasses
- purchase and fitting of prescription glasses (excluding prescription safety glasses) or elective contact lenses, as well as repairs, intraocular lenses following cataract surgery, or elective laser vision correction procedures, to a maximum of $450 per any consecutive months, combined for eye exams and prescription glasses
- visual training

Note: Reasonable and customary limitations do not apply to eye exams.

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $35 per visit to a maximum of $1,000 per calendar year combined for services of a chiropractor and physiotherapist (including athletic therapist)
- Massage Therapist - $50 per visit to a maximum of $500 per calendar year. Recommendation by a physician is required, once every 12 months.
- Speech Therapist - $1,000 per calendar year
- Physiotherapist - $1,000 per calendar year combined for services of a chiropractor and physiotherapist (including athletic therapist). Recommendation by a physician is required, once every 12 months.
- Psychologist - $35 for the initial visit, $20 for subsequent visits, to a maximum of $200 per calendar year

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 for Professional Services is not required, except for services of a massage therapist and physiotherapist (including athletic therapist), once every 12 months.

Medical Services and Supplies

Many items and services included under your benefit plan require a doctor’s recommendation. For more information on which items and services require a doctor’s recommendation, please contact Manulife Financial at 1-800-268-6195.

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 fundamental medical needs.

- Private Duty Nursing

Services for acute and palliative care 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 (or equivalent designation) who has completed an approved medications training program

Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

Charges for the following services are not covered:

- service provided primarily for chronic care, 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, wheelchairs and scooters

  - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals including the following:

  a) external insulin infusion pumps, batteries and repairs, up to a maximum of $6,600 per lifetime

  b) continuous positive air pressure (CPAP) machine including but not limited to the following supplies:

     i) initial battery

     ii) masks and parts of a mask (cushions, faceplate)

     iii) humidifier and its replacement parts

     iv) headgear and parts of the headgear

     v) hoses, tubing

     vi) power cord

Non-Dental Prostheses, Supports and Hearing Aids

- prosthetic arms, legs and myoelectric limbs (excluding repairs), up to maximum of $10,000. External breast prostheses, up to a maximum of one prostheses per breast per calendar year. If an internal breast prostheses is provided, payment will be limited to the cost of an external breast prostheses.

- surgical stockings, up to a maximum of 4 pairs per calendar year

- surgical brassieres, up to a maximum of 4 per calendar year

- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints

- back supports, up to a maximum of $80 per 3 calendar years

- cervical pillows, up to a maximum of $65 per calendar year
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a specialist physician, podiatrist, or chiropodist is required) and 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), up to a maximum of 3 pair(s) per 12 months for dependent children less than 19 years of age, and 1 pair per 12 months for any other person
- casted, custom-made orthotics, up to a maximum of 1 pair per 12 months (recommendation of either a specialist physician, podiatrist, or chiropodist is required)
- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $1,000 per calendar year

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- oxygen
- medicated dressings and burn garments
- viscosupplementation products and sperm washing
- cost of one mobility device
- food substitutes that must be administered through a feeding tube process
- hydroxy vitamin D testing
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $500 per lifetime
- diagnostic laboratory and x-ray procedures performed in the covered person's province of residence when coverage is not available in the provincial government plan, provided these procedures were covered under the prior plan as agreed upon by Manulife Financial and the TTC
- charges for the treatment of accidental injuries to sound natural teeth, provided the treatment begins within 90 days and is approved for payment within 12 months of the accident

Emergency 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.

  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 feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory.

Charges for the following are payable under this expense:

- physician's services
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available

The amount payable for these expenses will be limited to the same dollar amount as payable by OHIP. Other covered expenses will be reimbursed as currently outlined under this plan.

Covered expenses will be limited to reasonable and customary charges less the amount payable by the Provincial Plan, or which would have been payable had proper application been made.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Submitting a Claim

See section “How to Submit a Claim”.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you must advise the TTC that you have commenced a claim or action and provide a copy to the TTC. The TTC will request that you complete a subrogation agreement when you submit a claim for such expenses. You must include a reasonable amount in your claim or action to recovery amount paid in respect of your medical expenses.

Prior to settling your claim or action, you must advise the TTC of the amount of money you are recovering in respect of medical benefits paid and/or payable to you. The amount you recover in respect of medical benefits paid and/or payable to you in any settlement of your claim or action must be reasonable.

Upon settlement or judgment in your claim or action, you must immediately provide a copy to the TTC. You will be required to forthwith reimburse the TTC for medical benefits paid and/or payable to you from those amounts you recovered by way of settlement or judgement in respect of past or future loss of income if you exceed 100% of your loss.

Your benefits will be suspended if you fail to sign a subrogation reimbursement agreement.

Exclusions

No Extended Health Care benefits are payable for expenses related to:

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by the TTC's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Dental Care

Your Dental Care Benefit is provided directly by the TTC. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and the TTC's Benefit Plan.

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 Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Dental Association Approved Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

100% for Level I - Basic Services

100% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

50% for Level V - Orthodontics

Benefit Maximums

unlimited for Level I, Level II and Level III

$2,500 per calendar year for Level IV

$4,000 per lifetime for Level V

Termination Age - end of the month in which you retire. At retirement, if you are covered under the TTC’s dental plan the day before retirement and eligible for a pension from the TTC, then coverage may continue under the appropriate retiree plan (if retired on or after January 1, 2003), provided you have 10 or more years of service or 29 years of credited pension service.

Waiting Period - first of the month coincident with or next following 6 months of continuous or cumulative service from the date of hire

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 their license, or a denturist working within the scope of their license
- are reasonable as determined by Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, do not exceed the established maximums of your Benefit Plan, or do not exceed reasonable and customary charges as determined by Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the TTC will pay benefits as if the least expensive course of treatment were used. Manulife Financial will determine the adequacy of the various courses of treatment available, through a professional dental consultant. For example, dental implants will be reimbursed at the cost of a bridge.

Level I - Basic Services

- complete oral exam, one per 3 calendar years
- full-mouth x-rays, one per 3 calendar years
- cephalometic x-rays, one per 3 calendar years
- panoramic x-rays, one per 3 calendar years
- recall exams, bitewing x-rays, and fluoride treatments, once every 6 months
- microbiological tests
- local anesthetic (needle/freezing)
- dental caries susceptibility tests
- appliances for the control of harmful habits, including related observations, adjustments, repair, alterations and removal
- routine diagnostic and laboratory procedures
- one unit of light scaling and one unit of polishing, once every 6 months, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months, when the service is performed in Quebec
- oral hygiene instruction, once every 6 months but not including audio-visual oral hygiene instruction
- space maintainers (appliances placed for orthodontic purposes are not covered)

- fillings (amalgam, silicate, acrylic and composite), prefabricated posts, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- minor surgical procedures, simple extractions, and post surgical care
- complicated 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

Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery, alveoplasty or gingivoplasty performed in conjunction with extractions, and surgical movement of teeth)
- tooth coloured retainers and pontics on molars, limited to the cost of metal retainers and pontics
- treatment of fractures, including related bone grafts to the jaw
- treatment of maxillofacial deformaties, including related bone grafts to the jaw and cheiloplasty
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, not including periodontal re-evaluations, but including:
  - scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year
  - provisional splinting
  - occlusal equilibration, up to a maximum of 4 units per calendar year
- chemotherapeutic and/or antimicrobial agents, topical application, one unit of time
- endodontic services (which include root canals and therapy, bleaching of endodontically treated teeth, root amputation, apexifications and periapical services), but not including isolation of teeth and enlargement of pulp chamber. Root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime. Re-treatment is covered only if the expense is incurred more than 18 months after the initial treatment.

Level III - Dentures

- initial provision of full or partial removable dentures
- denture relines, remakes, rebases, adjustments, repairs, additions, tissue conditioning and resetting of teeth
- resilient liner

- precision dentures

- replacement of removable dentures, provided the new dentures are necessary due to one of the following:

  - a natural tooth is extracted and the existing appliance cannot be made serviceable

  - the existing appliance is at least 60 months old and cannot be made serviceable

  - the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent denture. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures.

- remodeling of the floor of the mouth

- remodeling and recontouring oral issues

- vesibuloplasty, reconstruction, of the alveolar ridge and extensions of mucous folds

- stents

Level IV - Major Restorative Services

- crowns and onlays, but not including recontouring of existing crowns (only when function is impaired due to cuspal or incisal angle damage caused by trauma or decay).

- gold foil restorations

- inlays (covering at least 3 surfaces, provided the tooth cusp is missing)

- initial provision of fixed bridgework

- replacement of fixed bridgework or the addition of teeth to bridgework, provided the replacement or addition is due to one of the following:

  - a natural tooth is extracted and the existing appliance cannot be made serviceable

  - the existing appliance is at least 60 months old and cannot be made serviceable

  - the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent bridge. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.

- implants, or any services rendered in conjunction with implants only when an implant is the choice of treatment and a bridge would produce professionally adequate results for the condition. The plan will pay the cost of the implant expense and any related services, at a cost equal to the cost of a bridge.

Level V - Orthodontics

- correction of malocclusion of the teeth
- observation and adjustment
- appliances for tooth guidance or uncomplicated tooth movement
- retention appliances
- fixed or cemented, unilateral and bilateral appliances

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $400, 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.

Submitting a Claim

See section “How to Submit a Claim”.

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you must advise the TTC that you have commenced a claim or action and provide a copy to the TTC. The TTC will request that you complete a subrogation agreement when you submit a claim for such expenses. You must include a reasonable amount in your claim or action to recovery amount paid in respect of your dental expenses.

Prior to settling your claim or action, you must advise the TTC of the amount of money you are recovering in respect of dental benefits paid and/or payable to you. The amount you recover in respect of dental benefits paid and/or payable to you in any settlement of your claim or action must be reasonable.

Upon settlement or judgment in your claim or action, you must immediately provide a copy to the TTC. You will be required to forthwith reimburse the TTC for dental benefits paid and/or payable to you from those amounts you recovered by way of settlement or judgement in respect of past or future loss of income if you exceed 100% of your loss.

Your benefits will be suspended if you fail to sign a subrogation reimbursement agreement.

Exclusions

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

- self-inflicted injuries
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices

- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by the TTC's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, the TTC will continue the Dependent benefits, provided benefits are elected and monthly premiums are paid by your surviving spouse, under the appropriate survivor plan as outlined under Plan E, to the end of the month in which your spouse dies for Extended Health Care, and to the end of the month in which your spouse attains age 65 or dies for Dental Care. Only a dependent child who was a covered dependent prior your death will be eligible for continued coverage, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms),
- the end of the month in which your surviving spouse dies,
- the date similar coverage is obtained elsewhere,
- the date the Plan Document terminates, or
- the due date of the first payment to which the dependents have not made a required premium payment for survivor coverage.

If the surviving spouse remarries or is in a new common law relationship, the new spouse and new spouse's children are not eligible for coverage.

Short Term Disability – Sick Benefit Association Plan

The following is a summary of benefits available under the Sick Benefit Association (SBA). For further information please refer to the SBA By-laws.

ELIGIBILITY

All regular status unionized employees of TTC will become Members of the Sick Benefit Association (SBA) and will be eligible for sick benefits, after two (2) months of continuous service.

Temporary status and non-union employees will become Members of the SBA immediately on transfer to regular unionized status, provided they have completed at least two months of continuous service.

If you are not actively at work on the day your coverage would otherwise be effective, your coverage will become effective on the first day you are actively at work and perform all duties of your regular occupation.

HOW TO APPLY FOR SICK BENEFITS

Claim forms are available at each work location or from the Occupational Health & Claims Management office, Human Resources Department, 1138 Bathurst Street. All applications to the Association for payment of benefits must be made within 30 days of the date of absence.

The front page, i.e. Section 1 of the claim form, must be completed and signed by the employee; the attending physician must fully complete the medical certification portion of the form and sign it. The claim form is to be submitted to the Sick Benefit Association, Occupational Health & Claims Management office, Human Resources Department, Hillcrest.

NOTE: Any changes to the Medical section of the claim form must be initialed by the physician who completed the claim.
Incomplete Claims or Claims with insufficient information will be returned to the Member for additional information.

SICK BENEFITS/MAXIMUM PERIOD PAYABLE

The sick benefit payable, for a Member who qualifies, is 75% of the Member's base wage rate less all statutory deductions, including taxes, CPP, EI, family responsibility, union dues, etc. in effect on the date of the disability.

Effective September 1, 2014, employees will not be paid SBA payments for the first full day of absence due to illness that a Member is otherwise eligible to receive payment for under SBA By-laws, for the fourth sick incident and each subsequent incident, in each calendar year.

Sick Benefits are payable for a maximum period of 130 work days for each separate period of disability.

AGE 65 - Members who are age 65 or older, shall be limited to 130 work days of benefits in any 12 month period. Commencement of such 12 month period shall not be prior to the date on which the Member attains age 65.

If a Member becomes ill after reporting for work, the Member may be eligible to receive sick benefits for the remaining hours in the normal work day (8 hours for an employee working a 5 day, 40 hour week). Sick benefits shall be payable for a maximum period of 130 work days or 1040 hours for any one disability.

To qualify for sick benefits a member must be under the care of and follow the instructions of a licensed medical practitioner during the period for which application for benefits is made.

NOTE: Members are required to be treated within 72 hours.

In the event that a Member's disability commences the day preceding a statutory holiday or on a statutory holiday and/or weekend, payment for this period will be made provided they are clinically assessed by a licensed medical practitioner on the first day following these said periods.

Telephone treatment/consultations or instructions are not acceptable under the by-laws. Faxed copies of SBA applications will not be accepted.

Certificates of licensed medical practitioners are required on claims for sick benefits.

TTC Advances - Occupational Injury

If a member sustains an occupational injury and applies for benefits under the Workplace Safety and Insurance Act (”WSIA”) and the Workplace Safety and Insurance Board (”WSIB”) does not make a decision regarding the claim within 10 business days from the date of the Employer’s Report of Injury/Disease (Form 7), the Member may apply for TTC Advances, provided a “Direction” form is completed and signed.

If a Member is assaulted by a customer or witnesses a suicide while in the course of employment and applies for benefits under the Workplace Safety and Insurance Act (”WSIA”) and the Workplace Safety and Insurance Board (”WSIB”) does not make a decision regarding the claim within 3 business days from the date of the Employer’s Report of Injury/Disease (Form 7), the Member may apply for TTC Advances, provided a “Direction” form is completed and signed.

NOTE: Members are required to be treated within 72 hours.

In the case of a 3rd party claim, a Member may be eligible for TTC Advances upon submission of the signed **“Election to Claim Compensation”** Form.

Subrogation:

Non Occupational Injuries Caused by a Third Party:

If you are injured outside of work (non-occupational) and you commence a claim or action for damages against the third party that caused your injury you must: (a) tell the TTC that you started the claim or action; (b) provide a copy of the Statement of Claim to the TTC; and (c) sign a subrogation reimbursement agreement. You must also include in your claim or action an amount to recover Long Term Disability (“LTD”) Benefits paid and/or payable to you.

Prior to settling your claim or action, you must advise the TTC of the amount of money you are recovering in respect of LTD benefits paid and/or payable to you. The amount you recover in respect of LTD benefits paid and/or payable to you in any settlement of your claim or action must be reasonable.

Upon settlement or judgment in your claim or action, you must immediately provide a copy to the TTC. You will be required to forthwith reimburse the TTC for LTD Benefits paid and/or payable to you from those amounts you recovered by way of settlement or judgement in respect of past or future loss of income if you exceed 100% of your loss.

If you choose not to commence a claim or action or your fail to actively pursue recovery of LTD Benefits paid or to be paid against the third party that caused your injury, the TTC may bring an action in your name to recovery LTD Benefits paid and/or payable to you.

Your benefits will be suspended if you fail to sign a subrogation reimbursement agreement.

Occupational Injuries Caused by a Third Party:

If you suffer a workplace injury caused by a third party and you elect to commence a claim or action rather than to receive benefits under the *Workplace Safety and Insurance Act* (“WSIA”), you may apply for LTD Benefits. However, the amount of LTD Benefits you may be entitled to receive will be reduced by the amount of any disability benefits you receive and/or are entitled to receive.

If you elect to receive benefits under the WSIA, the TTC may commence a claim or action in your name in order to recover any benefits paid and/or payable to you under the WSIA.

OUTSIDE PROVINCE/CANADA

1. **A Member who has reported sick and who may or may not be in receipt of sick benefits and who is considering leaving the Province/Canada for a specified time period, the following process applies:**

   a) Must contact the Disability Management Specialist or Claims Adjudicator of the TTC Sick Benefit Association, and

   b) Must provide report from treating physician certifying Member is medically fit to leave Province/Canada for specified period and

   c) Approval from Director Occupational Health & Claims Management, Human Resources Department before leaving Province/Canada.

2. **A Member to qualify for sick benefits while receiving medical care outside Province/Canada, must:**

   a) receive medical treatment in an approved hospital (i.e. approved hospital as defined by the Ontario Health Insurance Plan) or be seen by and receive medical treatment from an approved licensed medical practitioner for whom the Ontario Health Insurance Plan has paid part or all of the medical fee;

   b) provide a medical certification of disability on the hospital's recognized Medical Certificate or formal document from the respective country, or provide from OHIP written proof that they have accepted and made payment in part of all of the medical fee from the practitioner;

   c) provide a Medical Certificate signed by a practitioner stating the disability, diagnosis, treatment, duration and the Member's name and date of birth; and

   d) obtain, at the Member's own expense, a certified translation of any documents substantiating the Member's claim for benefits.

A Member may be required to provide additional information.

New Period of Disability or Recurring Disability
(Long Term Disability Benefits)

A Member who is in receipt of long term disability benefits and who subsequently returns to work on a full time basis is not eligible for sick benefits unless the following conditions are met:

a) the subsequent disability is separated from the immediately preceding disability by 130 work days OR longer of full time continuous employment; or

b) the subsequent disability is due to an injury or illness entirely unrelated to the causes of the immediately preceding disability.

BENEFITS PAYABLE IN NOVEMBER AND DECEMBER

Benefits payable in November and December will be paid only after the Member has taken the current year's vacation.

EMPLOYMENT INSURANCE

If a Member is disabled beyond the 130 work days provided by the Sick Benefit Association, the Member may be eligible for a further 15 weeks of benefits payable by the Employment Insurance Commission.

If your claim is denied, a copy of the confirmation of the Employment Insurance denial must be provided to the Claims Adjudicator.

COST

a) The cost to provide this income benefit is paid for by the TTC.

b) Medical certificate - The TTC will reimburse $10.00 for the physician's statement if fully completed. The treating physician must quote the SBA number and submit to the TTC for payment. If the Member is required to pay the treating physician directly, the Member is to submit the official receipt from the treating physician certifying that payment was received. All invoices or receipts must be submitted within 90 days of the end of the calendar year, i.e. March 31st.

NOT COVERED

Sick Benefits are **not** payable for:

a) any disability resulting directly or indirectly from treatment or surgery for cosmetic purposes;

b) any self-inflicted injury or illness;

c) any period of disability that the Member is receiving wages or vacation pay from the Commission;

d) requested and granted/authorized leave of absence; or

e) time lost beyond one half day for tests and examinations unless the effects of such examinations and tests prevent the Member from performing the duties of their regular or any other job; periods while outside Province/Canada unless all of the requirements have been met.

Long Term Disability

Your Long Term Disability Benefit is provided directly by the TTC. Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and the TTC's Benefit Plan.

For further information regarding this benefit, please refer to the Letter of Understanding RE: Long Term Disability Benefit that is available from your Union Office.

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

Definition of Totally Disabled

For the qualifying period and the first 24 months immediately following the qualifying period, totally disabled means you are wholly and continuously disabled due to an illness or accidental injury which prevents you from performing any and every duty of your own occupation.

After the 24 month period, totally disabled means you are unable to perform any and every duty of any occupation for remuneration or profit with the range of your 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 - 60% of monthly earnings, to a maximum of $2,550

Qualifying Period - 26 weeks plus exhaustion of Employment Insurance benefits (if applicable), accumulated vacation, floater days and lieu time

- 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 - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Waiting Period - 3 months

Entitlement Criteria

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

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 30 days due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled.

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that:

  - for the qualifying period and the first 24 months immediately following the qualifying period, you are wholly and continuously disabled due to an illness or accidental injury which prevents you from performing any and every duty of your own occupation, and

  - after the 24 month period, you are unable to perform any and every duty of any occupation for remuneration or profit with the range of your 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 selected by Manulife Financial.

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount 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 government motor vehicle automobile insurance plan or policy, unless prohibited by law

- any group disability plan sponsored by the TTC

- any retirement or pension plan (excluding any private/personal plan) providing income that becomes payable after the Employee is no longer Actively At Work, whether or not the retirement income is related to the disability

- earnings or payments from any employer, including severance payments and vacation pay

- self-employment

- any government plan, excluding Employment Insurance Benefits and retirement plans

- any government plan providing retirement income benefits that becomes payable only after the Employee is no longer Actively At Work, and

- earnings from a salary continuance plan of the TTC

The amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross earnings. All sources include those sources stated above.

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

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 from sources, other than negotiated ad hoc adjustment, will be taken into consideration and a new benefit amount may be established
- benefits payable under individual disability income insurance will not be taken into account
- for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial, and
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated and offset from your Long Term Disability Benefit by Manulife Financial
- if you are injured at work and commence a claim or action for damages against a third party rather than apply for Workplace Safety and Insurance Board (WSIB) benefits, your Long Term Disability Benefit will be reduced by the amount of WSIB benefits you would have been entitled to receive had you applied

Subrogation

Subject to any deductions against the amount of disability benefits payable, conditional monthly payments shall be made to you with a potential loss of income claim against a third party who caused or contributed to the disability.

If you suffer personal injury or loss for which the covered person has a right to bring action for damages against a third party, TTC shall be subrogated to the covered person's rights to recover damages to the extent that it may be obligated to pay benefits to the covered person. In such case, TTC will require you to complete a subrogation reimbursement agreement. TTC has the right to suspend payment of benefits until the completed agreement is received. Upon judgement or settlement for damages, you shall reimburse TTC for benefits paid or payable.

For work related accidents, please refer to the last bullet item under Benefit Calculation Rules.

Unless notified to the contrary, the covered person's solicitor shall also represent the Employer's interests in such a recovery.

Tax Status

This disability benefit is fully taxable and subject to deductions as are required by law.

Payment of Disability Benefits

Disability benefit payments will be made monthly in arrears. 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.

Long Term Disability Top-Up

After exhausting SBA benefits, and if you are returning to work under a TTC approved return to work plan, you may be eligible for Long Term Disability Top-Up rehabilitation benefits.

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.

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 the TTC, Manulife Financial will provide a structured Vocational Plan that will prepare you for a return to work, either:

- with the TTC
- with an alternate employer
- in a self-employed capacity

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 85% 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:

  - for the qualifying period and the first 24 months immediately following the qualifying period, you are wholly and continuously disabled due to an illness or accidental injury which prevents you from performing any and every duty of your own occupation, and

  - after the 24 month period, you are unable to perform any and every duty of any occupation for remuneration or profit with the range of your education, training or experience

- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date on which benefits have been paid up to the Maximum Benefit Period or Termination Age for this benefit (to age 65 or retirement)
- the date of your death

Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, 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 for this benefit.

If the same disability recurs more than 6 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 full shift.

Submitting a Claim

To submit a claim, you and your treating physician must complete Long Term Disability claim forms which will be sent to you by TTC's Occupational Health and Claims Management, Human Resources Department.

An original completed claim form must be submitted to TTC's Occupational Health and Claims Management within 90 days from your Long Term Disability qualifying date.

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

- on leave of absence during which you become Totally Disabled, unless the TTC is required to pay benefits during this period as a result of legislation, regulation or case law
- receiving benefits under the TTC-sponsored salary continuance or short term wage loss replacement plan
- working in any occupation, except as provided for under the Rehabilitation Assistance provision
- incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

Exclusions

No benefits are payable for any disability related to:

- self-inflicted injuries or illnesses
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- medical or surgical care which is not medically necessary
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Manulife Financial
- injuries or illnesses sustained during course of employment other than at TTC

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.