MDA
EMPLOYEE BENEFITS INFORMATION HANDBOOK
FOR
MEMBERS OF UNIFOR
LOCAL 673

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Macdonald, Dettwiler and Associates Inc. (“MDA” or “The Company”)

MDA’S CORE VALUES

Our Values

- **We put the mission first:** Everything we do is to satisfy the goals, ambitions and dreams of our customers.
- **We stay curious:** We never stop working to discover the answers to the questions of tomorrow and to solve the most difficult problems
- **We do it right:** We operate with high integrity. No shortcuts. We honor our commitments to our customers, our partners and our employees.
- **We work better together:** We are an organization that values collaboration and diversity to create a better future.
- **We act like owners:** We know that results matter and we continually find new ways to grow, improve, and deliver sustainable value.

PLANS

Our Employee Benefit Plans are an expression of genuine concern for you and your family. Together with government sponsored programs and your personal savings, the Plans will assist you in building a solid foundation for your future. The Plans are designed to provide protection against medical and dental expenses together with loss of income from sickness or accidents.

GENERAL INFORMATION

This booklet contains important information concerning your group benefits and therefore should be kept in a safe place. It supersedes and replaces all previous communication material.

The information contained in this booklet summarizes the benefits and provisions of your group benefit plans. It does not constitute the group policies and is not a contract of insurance, nor does it create or confer any contractual or other rights. Every effort has been made to ensure that the information is accurate. If there is any question of interpretation, however, all rights with respect to covered employees will be governed solely by the Group Contracts and Plan Documents issued to MDA by the insurance carriers.

The Company is providing this benefit coverage in conjunction with government sponsored programs based on the assumption that benefits, services and supplies currently covered under government programs will continue to be covered in the future. In the event that this government coverage is suspended, discontinued or modified in any way, the Company will not automatically assume responsibility for any benefits, services or supplies previously covered under the government programs.

The adjudication of benefits by the insurance company is based on their current standard policies and administrative practices. The premiums are paid by MDA as they come due without any pre funding for future benefit obligations. The Company reserves the right to amend or discontinue all benefit plans from time to time, with or without notice.

Information on retiree benefits is outlined in a separate information document.

If you have any questions or require further information about your benefits coverage, please contact your Human Resources Department.

Effective Date of the Group Benefit Plans

The plans described in this handbook are effective as of October 18th, 2017 and include negotiated benefit changes through to **August 4th, 2020.**

Eligibility

All full-time MDA employees who are in the bargaining unit represented by UNIFOR Local 673 in Metropolitan Toronto and are Canadian residents, or Canadian residents on temporary assignment outside of the Brampton location, are eligible to participate in these benefit plans after they serve the applicable waiting period. Eligibility for extended health coverage is dependent on proof of applicable provincial health coverage.

Basic Life Insurance, Optional Life Insurance, Survivor Income Benefit, Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance

General Provisions

Effective Date of Coverage

Your Basic Life Insurance, Survivor Income Benefit, Basic Accident Insurance and Business Travel Accident Insurance coverage on the date immediately following 30 continuous working days of employment with the Company. You are eligible to apply for Optional Life Insurance coverage on your date of hire with the Company. Coverage will take effect following approval by the insurance company.

If you are not actively at work on the date your coverage or any change in coverage would normally become effective, coverage will commence on your return to work.

Termination of Insurance

Your insurance will cease on the earliest of the following dates:

- The date you terminate your employment or retire from the Company;
- The date you no longer have an eligible survivor (this applies to the Survivor Income Benefit);
- The date of your death; or
- Your entry into the Armed Forces on a full-time basis.

Continuation of Coverage

On temporary lay-off, your Basic Life Insurance, Survivor Income Benefit and Basic Accident Insurance coverage continues for up to 3 months following the month you are laid off at no cost to you. After this period, you may continue your insurance coverage with the exception of Accidental Death & Dismemberment for as long as you are eligible for recall but no longer than 24 months by paying the full cost of the required premiums in advance with post-dated cheques. Basic Accidental Death & Dismemberment Insurance may be continued for a further 9 months only by paying the full cost of the required premiums.

If you are on an approved leave of absence not related to disability, paid vacation or maternity/parental leave, your Basic Life Insurance, Survivor Income Benefit and Basic Accidental Death & Dismemberment Insurance coverage continues for 1 month following the month your leave commences at no cost to you. After this period, you may continue your insurance coverage for 11 months by paying the full cost of the required premiums in advance with post-dated cheques.

On temporary lay-off or non-disability approved leave of absence, your Optional Life Insurance will continue until the last day of the month following the month in which the lay-off or leave starts.

Basic Life Insurance Benefit

If you should die, regardless of the cause (other than those exclusions set out under “Exclusions”), your beneficiary will receive $66,000. You may change your beneficiary at any time subject to the laws governing such changes.

Conversion Option

If your Basic Life Insurance terminates or reduces while coverage on the group continues, you may convert your Basic Group Life Insurance to an individual life insurance policy, equal to or less than your Basic Life amount, subject to an overall conversion maximum of $200,000 of insurance. The individual life insurance policy will be issued without proof of satisfactory health provided the completed application form, along with the necessary premium, is mailed to the insurance company within 31 days of your date of termination.

This feature is usually only advantageous for people who would otherwise be unable to obtain insurance at standard rates due to their medical history and health risks.

If you die during the 31 day period in which you are eligible to make application for conversion, the amount of your Group Life Insurance available for conversion will be payable.

Claims procedures

If you should die, MDA will provide the necessary claim forms to your beneficiary for completion and submission to the insurance company.

Optional Life Insurance Benefit

You may purchase additional Optional Life Insurance coverage in units of $10,000 subject to a maximum of $200,000. You must complete an application form for this coverage.

Payment of Premiums

Participation in the Plan is optional and you pay the total premium cost through regular payroll deductions. The premium rate is established based on your age, sex and the amount of coverage you elect to purchase.

Monthly Premiums per $10,000 of Insurance		
Your Age	**Male**	**Female**
Up to and including age 39	$0.50	$0.30
40 to 44	1.10	0.70
45 to 49	1.80	1.20
50 to 54	2.90	1.90
55 to 59	4.70	3.10
60 to 64	6.60	4.40
60 to 69	10.70	7.10

Eligibility

You are eligible to participate in the Optional Life Insurance Plan on your date of hire.

Effective Date of Coverage

Coverage will take effect on the date your application is approved by the insurance company.

When you apply for coverage, you will be required to complete an application which includes health and lifestyle questions and you may be required to submit satisfactory evidence of your good health to the insurance company.

Termination of Coverage

Subject to the payment of the monthly premium, your Optional Life coverage will stop at the end of the month in which the earliest of the following occurs:

- The date you terminate your employment or retire from the Company;
- The date outlined in the “Continuation of Coverage” section on page 2 on temporary lay-off or approved leave of absence; or
- The date you attain age 70.

Total Disability

If you become totally disabled prior to age 65 as a result of an injury or illness, your Optional Life Insurance coverage will continue up to age 65 without payment of premiums as long as you remain totally disabled. You will be considered totally disabled if your illness or injury prevents you from doing any type of work whatsoever for at least six months.

Conversion Privilege

You may convert your Optional Life Insurance coverage to an individual policy under the same conditions described in the Basic Life Insurance section of this booklet.

Claims Procedures

If you should die, MDA will provide the necessary claim forms to your beneficiary for completion and submission to the insurance company.

Survivor Income Benefit

Your Survivor Income Benefit will provide your surviving dependents with a monthly income in the event of your death prior to age 65 or retirement. The Transition Benefit is payable for up to 24 months for your surviving spouse, dependent children, or dependent parents. Once the maximum Transition Benefit has been paid, a Bridge Benefit becomes payable to your surviving spouse until the earlier of remarriage or eligibility for Old Age Security benefits.

Your beneficiary is your spouse or dependent parents, as designated by you. Your children are automatically considered as eligible survivors without the requirement that you designate them.

Eligibility

You are eligible for this coverage if:

- you have dependents as defined below, and
- the benefits payable to your surviving dependents under the Company Pension Plan are less than those which would be provided under this Plan.

Definition of Dependents

Your eligible dependents are your spouse, dependent children and dependent parents. A dependent parent is natural or adoptive mother or father, of the employee who was dependent on the employee for at least 50% of their support in the 12 months immediately prior to the employee’s death.

Transition Benefit

If you should die while your Survivor Income Benefit coverage is in force, your spouse will receive a monthly income, known as a Transition Benefit, equal to $600 per month less any benefits payable to your spouse under the Canada / Quebec Pension Plan or Old Age Security Benefits. The minimum benefit payable to your surviving spouse is $300 per month.

If you do not have an eligible spouse (or your spouse dies), a benefit of $150 per month will be paid jointly to your eligible dependent children (regardless of the number of children). Payment will continue until the youngest child reaches the limiting age. Benefits for dependent children age 18 or older will be made directly to the children. Benefits for children under 18 years of age will be made to the person who is the child's principal support until a guardian is appointed.

If you do not have a surviving spouse or eligible dependent children, a benefit of $150 per month will be paid to your dependent parent or parents.

Transition Benefit payments will stop on the earliest of the following events:

- the date 24 monthly payments have been made;
- for dependent children, the date your youngest child has reached the limiting age; or,
- the date there are no surviving eligible dependents.

Bridge Benefit

An additional benefit, known as a Bridge Benefit, is payable to your surviving spouse following the final Transition Benefit payment, provided your spouse:

- is at least 40 years of age at the date of your death; and
- has received 24 monthly payments under the Transition Benefit.

The Bridge benefit is equal to $550 per month less any benefits payable to your spouse under the Canada/Quebec Pension Plan.

Bridge Benefit payments will stop on the earliest of the following events:

- the date your spouse remarries;
- the date your spouse becomes eligible to receive Old Age Security Benefits under any Federal or Provincial legislation; or
- the date of your spouse's death.

Conversion Privilege

Should your Survivor Income Benefit coverage terminate or reduce while coverage on the group continues, you may convert your insurance to an individual life insurance policy under the same conditions described under "Basic Life Insurance". You may convert all or part of the commuted value of your Survivor Income Benefit amount, subject to an overall maximum of $200,000.

Total Disability

If, prior to age 65, you become totally disabled for a continuous period of at least 6 months, your Survivor Income Benefit coverage will continue for as long as you remain totally disabled, up to age 65 or the date

your insurance would otherwise normally terminate. “Totally disabled” means you are wholly and continuously disabled by a sickness or accident which prevents you from working for your employer for wages or profit.

Claims Procedures

If you should die, MDA will provide the necessary claim forms to your survivor(s) for completion and submission to the insurance company.

Basic Accidental Death and Dismemberment Benefit

As an employee of MDA, you are covered under the Company’s Basic Accidental Death and Dismemberment Plan for an amount equal to 50% of your Basic Life Insurance coverage. The coverage applies 24 hours a day, on or off the job, anywhere in the world. The maximum amount payable is $33,000.

The largest benefit, but not more than one benefit, shall be payable with respect to injuries or losses resulting from one accident. Benefits will be paid to you or, in the event of your death, to your named beneficiary under the Basic Group Life Insurance Plan. If death, dismemberment or loss occurs within 365 days from the date of the accident, the following benefits will be paid.

Benefits will be paid to you or, in the event of your death, to your named beneficiary under the Basic Life Insurance Plan.

Loss of:	**Percentage Payable**
Life	100%
Both hands or both feet	100%
Entire sight of both eyes	100%
Speech and hearing	100%
One hand and one foot	100%
Either one hand or one foot and the entire sight of one eye	100%
One arm or one leg	75%
One hand or one foot	66-2/3%
Entire sight of one eye	66-2/3%
Speech or hearing	66-2/3%
Thumb and index finger of the same hand	33-1/3%
Hearing in one ear	25%
Loss of use of:	
Both arms or both hands	100%
One arm or one leg	75%
One hand or one foot	66-2/3%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

The benefit amount described above will also be paid if, as a result of a covered accident, you suffer a loss due to the unavoidable exposure to the elements, within 365 days of the accident.

If as a result of the disappearance, wrecking or sinking of the conveyance in which you were riding at the time of a covered accident, you disappear, and the body is not found within one year following the accident, the benefit for loss of life will be payable on the presumption of death due to the accident.

Repatriation Benefit

When injuries covered by this Plan result in loss of life either outside the province of residence or outside Canada, within 365 days from the date of the accident, the Plan will pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased. The maximum payable is $15,000.

Rehabilitation Benefit

When injuries result in a payment being made under any benefits described above, excluding the Loss of Life benefit, the reasonable and necessary expenses actually incurred for special rehabilitation training are payable. Eligible training expenses must be necessary as a result of such injuries and must enable you to qualify for an occupation in which you would not have been engaged except for such injuries. Expenses incurred within two years from the date of the accident, up to $15,000, are payable. The Plan does not cover ordinary living, traveling or clothing expenses.

Exclusions under the Basic Accidental Death and Dismemberment Plan

This Plan does not cover losses resulting from:

- intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane;
- injury sustained while serving full-time in the Armed Forces of any country;
- illness, disease or bodily infirmity; and
- declared or undeclared war or any act thereof occurring within Canada and any other country which may be specifically excluded from war risk coverage.

You are covered for travel or flight in any civilian aircraft, transport type aircraft operated by the Armed Forces of any country, or other device for air travel, including boarding or alighting from the aircraft, provided the aircraft has a current unrestricted airworthiness certificate and is being operated by a properly certified pilot. You are **not** covered for air travel while:

- flying in any aircraft that is used for fire fighting, pipeline inspection, powerline inspection, aerial photography or exploration;
- flying as a pilot or member of the crew of any aircraft;
- being a passenger on an aircraft owned, leased or operated by you, a member of your household or MDA;
- travel or flight in any aircraft or device used for navigation beyond the earth's atmosphere; and
- parachuting, except when making a parachute jump for self-preservation.

Claims Procedures

Claim forms are available from your Human Resources Department. In the event you suffer a loss, you and MDA complete certain portions of the form and your doctor completes the Attending Physician's Statement. The completed forms are then forwarded to the insurance company for approval. It is important that these forms be submitted to the insurance company within 90 days of the accident. In the event of your death, your beneficiary should contact the Human Resources Department.

Termination of Coverage

Your Basic Accidental Death and Dismemberment coverage will stop at the end of the month in which the earliest of the following events occurs:

- The date you terminate your employment or retire from the Company;
- The date outlined in the "Continuation of Coverage" section on page 3 on temporary lay-off or approved leave of absence; or
- The date you attain age 70.

Business Travel Accident Insurance Benefit

You are insured against accidental death and dismemberment while you are travelling anywhere in the world on authorized business for the Company. Business travel includes both short errands around town as well as long trips away from your office but excludes normal commuting to and from work.

Benefits will be paid to you, or in the event of your death, to your named beneficiary under the Basic Group Life Insurance.

Amount of Insurance

You are covered for $200,000. Benefits are payable in the same manner as described under the Basic Accidental Death and Dismemberment Insurance section of this booklet.

Termination of Coverage

Your Business Travel accident coverage ceases on the earlier of the following dates:

- The date you terminate your employment from the Company; or
- The date you retire from the Company.

Exclusions under the Business Travel Accident Insurance

This Plan does not cover losses resulting from:

- intentionally self-inflicted injury, suicide or any attempt thereat;
- injury sustained while serving full-time in the Armed Forces of any country;
- illness, disease or bodily infirmity; and
- declared or undeclared war or any act thereof occurring within Canada and any other country which may be specifically excluded from war risk coverage.

You are covered for travel or flight in any civilian aircraft, transport type aircraft operated by the Armed Forces of any country, or other device for air travel, including boarding or alighting from the aircraft, provided the aircraft has a current unrestricted airworthiness certificate and is being operated by a properly certified pilot. You are **not** covered for air travel while:

- flying in any aircraft that is used for fire fighting, pipeline inspection powerline inspection, aerial photography or exploration;

- flying as a pilot or member of the crew of any aircraft;
- being a passenger on an aircraft owned, leased or operated by you, a member of your household or MDA;
- travel or flight in any aircraft or device used for navigation beyond the earth's atmosphere; and
- parachuting, except when making a parachute jump for self-preservation.

Claims Procedures

In the event of a claim, you or your beneficiary should contact the Human Resources Department. Proof of your claim must be submitted to the insurance company within 90 days of the accident.

Canada / Quebec Pension Plan
Death Benefits

If you die, additional benefits may also be payable from the Canada / Quebec Pension Plan. Your spouse will receive a lump-sum payment of up to 10% of the Year's Maximum Pensionable Earnings. In addition, your spouse may receive a monthly benefit if (s)he is over 35, or if there are dependent children. The Plan also pays benefits for each dependent child.

Semi-Private Hospital, Vision Care, Major Medical, Out-of-Country Medical Coverage and Prescription Drug Benefit Plans

General Provisions

MDA provides you with the following Health Plans which are designed to protect you from large and unexpected hospital and medical expenses:

- Semi-Private Hospital Benefit
- Vision Care Benefit
- Major Medical Plan
- Out-of-Country Medical Coverage
- Prescription Drug Benefit
- Dental Care Benefit

The Semi-Private Hospital, Vision Care, Major Medical, Out-of-Country and Medical Coverage benefits are administered by Great-West Life.

Prescription Drug and Dental Care Benefits are administered by Green Shield.

Effective Date of Coverage

You and your eligible dependents are covered:

- for Semi-Private Hospital, Major Medical, Out-of-Country and Vision Care benefits, on the date you complete a waiting period of 30 continuous working days of employment;
- for Prescription Drug benefits, on the first day of the month coincident with or next following your date of employment; and
- for Dental benefits, upon attainment of seniority.

If you have coverage for yourself only, and later acquire a dependent, your dependent will be enrolled in the Plan as of that date. You should advise your Human Resources Department immediately of any change in your status.

If you are not actively at work on the date your coverage would normally become effective, coverage will commence upon your return to work.

If one of your dependents is hospitalized (other than a new-born infant) on the date coverage would normally become effective, or was hospitalized within 31 days prior to the date coverage would normally become effective, coverage will commence on the day following discharge from the hospital. Coverage may commence earlier upon submission of satisfactory evidence of insurability.

Your eligible dependents are covered by the Health and Dental Plans described in this handbook, provided they are also covered by a Provincial Health Care Plan. Your eligible dependents for Health and Dental benefits are your spouse and dependent children as described below:

Spouse means a person who:

- is married to you through an ecclesiastical or civil ceremony; or
- although not legally married to you, cohabits with you for at least one year in a husband and wife relationship which is recognized as such in the community in which you reside at the time a claim is incurred. (This includes a same-sex relationship.)

Dependent Children means:

- unmarried children including adopted children, foster children and step-children under the age of 21 or age 21 or over but under age 25 if such child is residing with and dependent on you and is in regular full-time attendance at an accredited institute of learning; or
- other children who depend on you for support and live with you in a parent-child relationship if they meet the conditions set out above;
- mentally or physically disabled children may remain covered past age 21 (or age 25) provided the child is incapable of self-sustaining employment and is wholly dependent on you for support and maintenance.

Termination of Coverage

Semi-Private Hospital, Major Medical, Out-of-Country and Vision Care benefits will stop for you and your eligible dependents on the earlier of the date you terminate your employment with the Company or the date of your death. Prescription Drug benefits will stop for you and your eligible dependents on the earlier of the following dates:

- the last day of the month in which you terminate your employment with the Company; or
- for dependent children, the last day of the month in which the child ceases to qualify as a dependent.

The Company will continue to provide these benefits to you and your eligible dependents while you are receiving Short Term and Long Term Disability.

Continuation of Coverage

On temporary lay-off, your Semi-Private Hospital, Major Medical, Out-of-Country, Vision Care and Prescription Drug coverage continues for up to 3 months following the month you are laid off. After this period, you may continue this coverage for a further 24 months by paying the full cost of the required premiums in advance with post-dated cheques.

Semi-Private Hospital Benefit

The Semi-Private Hospital benefit pays 100% of the difference in cost between standard ward accommodation and semi-private accommodation in a licensed active-care hospital. An active-care hospital is one which has organized facilities for diagnosis and major surgery and 24-hour nursing care and is not primarily a clinic, chronic care, nursing, rest, or convalescent home.

Vision Care Benefit

The vision care benefit is not subject to the Major Medical deductible. Vision Care expenses are paid up to a maximum of $350 in any 24 consecutive months effective November 1st, 2017. For dependent children age 14 and under, expenses are paid up to $200 every twelve months. Vision Care expenses are

eligible when they are recommended by a physician (including an ophthalmologist) or an optometrist. Eligible expenses include the following expenses:

- Single vision, bifocal or trifocal lenses (including contact lenses) and frames. Eyeglasses for cosmetic purposes are not included;
- Contact lenses, up to a total payment of $350 per person in any 24 consecutive months effective November 1, 2017, if they are prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia and if visual acuity can be improved to at least the 20/40 level; and
- Eye examinations, including refraction, limited to one examination in any calendar year for dependent children and one in any 2 consecutive calendar years for any other covered individual. These examinations are not subject to the vision care maximum allowance but are subject to the major medical deductible and reasonable and customary charge limits.

If new eyeglasses or contact lenses are prescribed with a prescription change and purchased during a 24 month period in which you have already received the maximum benefit, you may submit this expense for reimbursement at the end of this 24 month period. You must still have Vision Care coverage at that time. Please submit both the old and new prescriptions with your claim. The next 24 month period will take effect from the time your second claim is paid.

Employees and their eligible dependents are permitted to use the Vision Care Benefit towards the cost of Laser Eye Surgery upon submission of appropriate documentation and original receipts.

Major Medical Plan

The Major Medical Plan helps pay for certain expenses not covered by your Provincial Plan.

After you have paid an annual deductible, this Plan pays 80% of the cost of eligible expenses, to a lifetime maximum of $45,000 (excluding ambulance and hearing aid covered expenses) for each covered person after you have paid a deductible in each calendar year. The deductible of $25 per individual is applied in each calendar year to the eligible expenses incurred in that year by the individual. In the case of a common accident involving two or more family members, only one individual deductible is applied against any eligible expenses in connection with the accident.

For you and each of your dependents, up to $1,000 of the overall maximum amount that has been paid in benefits will be automatically restored at the end of each calendar year, as part of the individual’s overall maximum.

Eligible expenses incurred in the last 3 months of a calendar year which were used to satisfy the deductible, either in full or in part, will be carried over into the following year to assist in satisfying the following year’s deductible.

Some types of expenses are not subject to the deductible (see below).

Eligible Expenses

Eligible services and supplies, with the exception of paramedical services, must be recommended by a physician. All charges for eligible expenses must be reasonable and customary.

Expenses NOT subject to the deductible or the lifetime maximum and reimbursed at 100%:

- Charges for emergency transportation services by a professional ambulance (including air and rail transportation) within Canada to the nearest hospital qualified to provide the required treatment, subject to a maximum of $50 per trip, 5 trips per calendar year; and

- Charges for the installation of a hearing aid or aids including repair and replacement, subject to a lifetime maximum of $1,000 per covered individual.

Expenses subject to the deductible and the lifetime maximum:

- Private room accommodation in a hospital. This benefit is also subject to a maximum of $4 per day over and above the semi-private room charges;

- Convalescent hospital charges. This benefit is subject to a maximum of $15 per day for 120 days per disability. In order to be eligible for this benefit, you or your dependent must be admitted to a convalescent hospital within 14 days of discharge from hospital. Subsequent periods of confinement in a convalescent hospital must be separated by at least 6 months. Charges for care that is custodial in nature are not covered;

- Out-of-hospital nursing care by a Registered Nurse prescribed by a physician, provided the nurse is not related to or residing with the patient;

- Physiotherapy expenses;

- Services of a Clinical Psychologist, on the recommendation of a physician, up to a maximum of $500 per individual per calendar year;

- Wigs required for permanent hair loss as a result of injury or disease, or for temporary hair loss as a result of medical treatment for any disease;

- Equipment rented, or purchased at the plan administrator's request, that is for temporary therapeutic use, including a raised toilet seat, versa frame, shower bars and grab bars, excluding an able walker. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair;

- Casts, splints, trusses, braces or crutches;

- Breast prostheses (covered at 100% after the deductible) or implant required as a result of surgery;

- Mastectomy bras, up to a maximum of 3 per person per benefit year, including prosthetic bras (covered at 100% after the deductible);

- Artificial limbs and eyes, including repairs and adjustments, or replacement if repair is not possible, or to accommodate a growing child, excluding myoelectric appliances;

- Stump socks, up to a maximum of 6 pairs per person in a benefit year;

- Elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year;

- Radiotherapy or coagulotherapy;

- Oxygen, plasma and blood transfusions;

- Diabetic supplies, including an insulin injector, insulin pump and glucose monitoring machine;

- PSA test (one per calendar year), where not covered by a Provincial Healthcare Plan;

- Custom-made orthopaedic shoes or modifications to orthopaedic shoes and custom-made orthotic inserts and arch supports for shoes when prescribed by a doctor, podiatrist or chiropodist, up to a combined maximum of $400 per person in a benefit year;

- Services of an Osteopath, Chiropractor, Podiatrist, Naturopath, Masseur and Speech Therapist up to a combined annual maximum of $1,000 per calendar year. Acupuncture is covered if administered by a licensed physiotherapist. No benefit is payable for these expenses while you are entitled to similar benefits under any Provincial Health Plan; and

- Charges for the medically necessary special needs of a terminally ill patient who, in the opinion of the attending physician, has a life expectancy of less than 6 months. Hospice care must be provided in an approved facility for a maximum period of 30 days, or provided by an accredited organization delivering such services on an out-patient basis. Such charges are subject to a maximum of $8,000 per person (which is in addition to the lifetime maximum for other major medical expenses).

Out-of-Country Medical Coverage

Your Provincial Plan covers most basic medical and hospital expenses incurred within Canada, even if the treatment takes place in another province or territory. For out-of-country expenses, however, your Provincial Plan coverage is more limited.

To supplement your Provincial Plan, the Global Medical Assistance covers eligible expenses incurred for emergency or referral treatment outside Canada. It also covers hospital charges incurred outside your province of residence within Canada that may not be fully covered by your Provincial Plan. In addition, Global Medical Assistance provides information services and financial assistance for other costs arising from out-of-country medical emergencies.

For details on how to claim out-of-country expenses, see page 18.

Eligible Expenses

All charges for eligible expenses must be reasonable and customary. Expenses above the amount covered by your Provincial Plan will be reimbursed as follows:

- Coverage will be at 100% without a deductible for emergency out of country care while on Company approved business;

- Coverage will be at 80% for emergency (non-business travel);

- Coverage for referred services will be at 80% after the deductible;

- Physicians' services outside Canada when
  a) obtained on the referral of a physician located in Canada,
  b) the treatment is not available in Canada, and
  c) the government insurance plan for your province of residence contributes to the cost incurred;

- Out-of-Canada physicians' charges are paid for expenses incurred on an emergency basis while travelling or vacationing outside Canada, for the difference between the benefit payable by the provincial hospital plan and what would be paid on a reasonable and customary basis; and

- Hospital charges incurred for emergency treatment while travelling, vacationing or otherwise temporarily residing outside your province of residence as follows:
  a) room and board, for the difference between the benefit payable by the provincial hospital plan and the actual cost of ward accommodation; and

b) hospital services and supplies furnished during hospital confinement (excluding room and board, physicians' fees and special nurse's fees).

Other expenses normally covered by your MDA Health Plans in Canada are also covered if incurred for emergency treatment while travelling, vacationing or temporarily residing outside Canada.

Services and financial assistance provided through Global Medical Assistance are **not subject** to the Major Medical deductible or lifetime maximum:

- a GMA card with 24-hour toll-free numbers for emergency information (such as referrals to a physician, hospital or translator);
- up to $500 for delivery of your vehicle to your home or rental agency in case of death or hospitalization for more than seven days;
- up to $2,000 for transportation home for your dependent children if you are unable to care for them, with an attendant if required;
- if you are hospitalized for more than seven days while travelling alone, a round-trip visit by a family member, including expenses of up to $150 per day, maximum 7 days;
- a return trip home for the insured person and one family member if a pre-paid flight has been missed, plus expenses of up to $150 per day, maximum 7 days, for a family member while the insured person is hospitalized beyond the scheduled departure date;
- emergency cash advances to cover medical bills; and
- up to $5,000 for return of the deceased's body in case of death.

Definition of "Emergency"

For the Emergency Travel Assistance Benefit, an "emergency" is an unforeseen event that requires immediate medical care. You are expected to consider your medical condition before you travel outside Canada. If, for example, you travel even though your doctor has advised you not to, then a sudden need for treatment relating to your previously known condition would not be considered an emergency.

Prescription Drug Benefit

This plan pays for prescription drugs after you have paid a deductible of $0.35 for each prescription (subject to reasonable and customary charge limits). The drugs must be purchased on the prescription of a medical doctor or dentist.

The plan pays for drugs, serums, injectables and insulin, including needles, syringes and testape for use by diabetics. It does not cover vitamins and vitamin preparations (unless injected), patent or proprietary medicines and drugs not approved for legal sale to the general public in Canada.

Claims Procedure

For this benefit you will be given an identification card showing your name, identification number and names of your dependents. This card is widely accepted at pharmacies throughout the country.

Some pharmacists have an agreement whereby they collect the 35¢ from you and then bill the Plan directly for the balance.

If there is no agreement with the pharmacist, pay for the prescription, obtain a claim form from the Human Resources Department and send it to Green Shield with your receipts attached. Claim forms are also available on the Company intranet site and on Green Shield's website at www.greenshield.ca. Be sure the receipts clearly show the prescription number, cost, date of purchase, name of the patient and quantity, strength and identification number of the drug. You will receive a cheque for the amount being reimbursed.

To claim for medicine injected by a physician, obtain a receipt for the medicine only and send it to Green Shield along with a Green Shield claim form. Reimbursement will be made for the cost of the injectable medicine only.

Other Medical Plan Provisions

General Exclusions

The Semi-Private Hospital, Major Medical, Out-of-Country, Vision Care and Prescription Drug Plans do not cover:

- Self-inflicted injuries or illness while sane or insane;
- Any injury or illness for which you or your dependents are entitled to indemnity or compensation under any Workers' Compensation Act;
- Cosmetic surgery or treatment (when so determined by the insurance company) is not covered unless such surgery or treatment is for accidental injuries and commences within 90 days of the accident;
- Injury resulting directly or indirectly from insurrection, war, full-time service in the Armed Forces of any country or participation in a riot;
- Services, treatment or supplies payable by a government plan. Should your government plan alter to include any of these items, coverage under this plan will automatically be adjusted in accordance with the approved legislation;
- Examinations required for use by a third party (for example, doctors' notes for time off work and summer camp or insurance medicals);
- Travel for health reasons;
- Service, treatment or supplies for which there would be no charge except for the existence of coverage. All eligible expenses must be reasonable, customary and recommended as necessary by a physician;
- Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;
- Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or advice given by telephone or other means of telecommunication. Drugs, sera, injectables and supplies which are not approved by Health and Welfare-Canada (Food and Drugs) or are experimental or limited in use whether or not so approved; and
- Expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services, except as specified under the Out-of-Country benefit or referral treatment under Major Medical eligible expenses. Such expenses incurred outside Canada on an elective basis are not payable.

Claims procedures

SEMI-PRIVATE HOSPITAL, MAJOR MEDICAL AND VISION CARE BENEFITS: Claim forms are available from the Company intranet site and on the Great West Life website at www.greatwestlife.com and your Human Resources Department. Complete the form, attach any relevant expense receipts or documentation and send the claim directly to Great West Life. Payment will be made directly to you.

OUT-OF-COUNTRY BENEFIT: Great-West Life is a registered billing agent with the Ministry of Health and will handle your out of country claims first, and submit them on your behalf to the appropriate Ministry of Health Office for assessment. Submit your health claim form and any relevant expense receipts or documentation, directly to Great-West Life.

PRESCRIPTION DRUG BENEFIT: Please refer to page 16.

In order for you to receive reimbursement for your eligible expenses, claims must be submitted to Great-West Life no later than the end of the calendar year following the year in which you incurred the expenses. If you terminate service with the Company, written proof of claim must be submitted within 90 days of your termination.

Co-Ordination of Benefits

This provision operates in the event that you or your dependents are covered under more than one Group Health Plan, and ensures that, although claims may be made under more than one plan, total reimbursement received does not exceed 100% of the actual expenses incurred.

Where both you and your spouse are working and have family coverage under your respective plans, claims should be submitted as follows:

Your claims should be submitted to the MDA plan first and then, if there is any unpaid balance, submitted to your spouse's insurance company along with a copy of your statement of benefits.

Your spouse's claims should be submitted to his/her insurance company first and then, if there is any unpaid balance, submitted to the MDA plan along with his/her insurer's statement of benefits.

Dependent children's claims should be submitted to the insurance company covering the parent whose day and month of birth occurs earlier in the calendar year. For example, if you are born July 7th and your spouse is born February 23rd, your spouse's insurance company is first payor for your dependent children's claims.

Dental Plan Benefits

The Dental Plan is designed to help pay for dental expenses incurred by you and your eligible dependents. Coverage includes preventive, restorative, major restorative and orthodontic services.

Termination of Coverage

Coverage for you and your dependents will stop on the earliest of the following dates:

- the date your terminate your employment with the Company;
- the end of the month in which you retire;
- the end of the month in which you begin a non-disability leave of absence other than Maternity or Parental Leave or lay-off;
- the end of the month following the month in which you die; or
- the date you enter the Armed Forces of any country on a full time basis.

Continuation of Coverage

Coverage for an employee who is laid off will continue until the end of the month following the month in which the employee last worked.

Total Disability

You and your eligible dependents continue to be covered by the Dental Plan while you are receiving Short Term and Long Term Disability benefits.

Eligible Expenses

Charges for dental services will be eligible for reimbursement provided a physician or dentist has recommended the services. Eligible expenses will be reimbursed based on a one year lag on the Ontario Fee Guide for General Practitioners (including Denturist Fee Guide where applicable) recognized under the Plan when the expense is incurred and by the level of reimbursement for the type of expense as indicated below:

Type of Expenses	Reimbursement Level	Maximum Benefit
Basic Services (Schedule “A”) Comprehensive Services (Schedule B”) Major Restorative Services (Schedule “C)	100% 100% 90%	Combined Annual Maximum of $3,000
Orthodontic Services	75%	Lifetime Maximum of $2,900

The Dental Plan covers the following services:

Basic Services

- Recalls including exams, bitewing X-rays, cleanings and fluoride treatments;
- Complete, general or comprehensive oral exams, full mouth x-rays and panoramic x-rays;
- Basic restorations, composite fillings for both anterior and posterior teeth and inlays; and
- Extractions and surgical services. General anaesthetics and intravenous sedation only when done in conjunction with eligible extraction(s) and/or oral surgery. Sleep dentistry is not eligible.

Comprehensive Basic Services

- Endontic treatment including root canal therapy;
- Periodontal treatment including scaling and/or root planning; and
- Standard denture service including relining and rebasing of dentures after 6 months from installation plus denture adjustments after 3 months from installation.

Major Restorative Services

- Dentures, complete, immediate and partial;
- Crown restorations or onlays on natural teeth;
- Repair or recementing of crowns, onlays and bridgework on natural teeth; and
- Bridges, including pontics, abutment retainers/crowns on natural teeth based on the date of the tooth/teeth extractions.

Orthodontic Services

- Orthodontic services (persons age 18 and under) require a treatment plan to be submitted by your Dentist/Orthodontist for prior approval of coverage eligibility.

Limitations

Replacement of prosthodontic appliances will be an eligible insured service only if 5 years have elapsed since the date of initial installation.

Relining and rebasing of complete or partial dentures will be payable provided it is more than 6 months after installation of an initial or replacement denture. Not more than one relining or rebasing will be payable in any 36 consecutive month period.

Orthodontic benefits are only eligible if the service is rendered prior to the attainment of 19 years of age.

Dental Treatment, Pre-Determination Plan

It is recommended that a pre-determination of benefits be filed with the insurance company whenever the total cost of proposed dental work is expected to exceed $300 or when treatment involves crowns, bridgework or orthodontic treatment. This pre-determination of benefits identifies coverage and limitations for specific services and clarifies benefits payable before dental treatment commences. In determining

the amount payable, consideration may be given to alternate procedures that may be performed for the dental condition concerned in order to accomplish the desired result.

The pre-determination is not intended to tell you or your dentist what treatment should be performed or what fee should be charged. It is simply intended to indicate in advance, the portion of the total cost your Dental Plan will pay and therefore, how much you must pay.

Co-Ordination of Benefits

This provision operates in the event that you or your dependents are covered under more than one Group Dental Plan. It ensures that, although a claim may be made under more than one plan, total reimbursement received does not exceed 100% of your actual incurred expenses. Where both you and your spouse are covered under your respective employer's plans for family coverage, your claims should be submitted as follows:

Your claims should be submitted to the MDA plan first and then, if there is any unpaid balance, submitted to your spouse's Dental Plan along with a copy of your insurer's statement of benefits.

Your spouse's claims should be submitted to his/her Dental Plan carrier first and then, if there is any unpaid balance, submitted to the MDA along with his/her carrier's statement of benefits.

Dependent children's claims should be submitted to the Dental Plan covering the parent whose day and month of birth occurs earlier in the calendar year. For example, if you were born April 5th and your spouse was born September 18th, your Dental Plan is first payor for your dependent children's claims.

General Exclusions

The Dental Plan does not cover:

- Charges for treatment other than by a dentist. Scaling and cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist;
- Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower front teeth;
- Charges for services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
- Charges for prosthetic services including bridges or crowns and the fitting thereof which were ordered while you or your dependent was not insured for Dental benefits or which are installed more than 60 days after termination of Dental coverage;
- Charges for replacement of lost, mislaid or stolen dentures, bridges or crowns;
- Charges for missed appointments;
- Charges for services or supplies for which you are entitled to indemnity or compensation under any Workers' Compensation Act;
- Services, treatment or supplies for which there would be no charge except for the existence of coverage;
- Charges for services or supplies which are not considered necessary according to accepted standards of dentistry.

- Any injury resulting directly or indirectly from insurrection, war, service in the Armed Forces or participation in a riot;
- Charges for services or supplies which do not meet accepted standards of dentistry, or are experimental in nature;
- Services, treatment or supplies payable in full by, or the portion of such services treatment or supplies which is payable by, a government plan;
- Charges for any duplicate denture, bridge, crown or appliance;
- Charges for completion of insurance forms;
- Charges for prescription drugs, sealants, oral hygiene or dietary instruction;
- Charges for a plaque control program; or
- Charges for implantology.

Claims Procedures

Claim forms are available from Human Resources or the Company intranet site. Alternatively, your dentist may use a standard dental claim form. These forms should be completed by your dentist and then by you prior to forwarding directly to Green Shield. Payment will be made directly to you, unless you assign the benefits payable to the dentist by indicating so on the claim form. In order to be eligible for reimbursement, claims must be submitted within 12 months from the date incurred.

Income Protection

General Provisions

Effective Date of Coverage

Your Weekly Indemnity and Long Term Disability coverage is effective on the date immediately following 30 continuous working days of employment with the Company.

If you are not actively at work on the date your coverage or any change in coverage would normally become effective, coverage will commence on your return to work.

Benefit Calculation

Your Long Term Disability benefits are calculated using your regular weekly earnings at your basic rate of pay plus any cost-of-living adjustment (COLA), but excluding overtime, shift premiums, or other extra payments.

Termination of Insurance

Your coverage will cease on the earliest of the following events:

- the date you terminate employment or retire from the company;
- the date of your death;
- the date you enter the Armed Forces on a full-time basis; or
- 52 weeks prior to the date you reach age 65 (for Long Term Disability).

Weekly Indemnity

Weekly Indemnity insurance is underwritten by Great-West Life.

If you are totally disabled, unable to perform the duties of your normal occupation and under the care of a physician, Great West Life will pay you the greater of a weekly income of $650 per week effective October 18th, 2017**,** or the maximum weekly Employment Insurance benefit. For Weekly Indemnity benefit, "totally disabled" means that, due to bodily injury or disease, you are unable to work for your employer for wages or profit.

Your Weekly Benefit will be reduced by any income you are eligible to receive from the following sources:

- Any government plan of automobile insurance providing income replacement indemnity which has been approved as an acceptable limitation by Employment Insurance; and
- Earnings or payments from any employer.

If you might qualify for any of the benefits listed above, it is your responsibility to apply for them and to provide any additional documentation that might be needed to support your claim.

If you have one or more years of seniority and become totally disabled during the first 52 weeks of lay-off and while on recall, you will be eligible to receive benefits from the date of recall. No benefits will be payable, however, if you become totally disabled beyond 52 weeks from the date of lay-off.

Commencement of Benefits

Benefits normally begin on the 4th day of disability. Benefits will begin on the 1st day of disability in the following situations:

- You are hospitalized;
- You required outpatient surgery and as a result lose a full day's pay; or
- Your disability was the result of an accident.

In order for benefits to be payable from the first day of hospitalization, you must be a registered bed patient who has been formally admitted and assigned to a bed in hospital on a physician's order.

Maximum Benefit Period

During any one period of disability, your benefits will continue until you recover or have received a maximum of 52 weeks of benefits, whichever is earlier. You may be requested to undergo a physical or mental evaluation or to submit proof of your ongoing disability. Failure to do so when requested may result in the termination of benefit payments.

Weekly Indemnity benefits will terminate on the earliest of the following dates:

- The date you are no longer disabled;
- The date you have received 52 weeks of benefit;
- The date you retire; or
- The date of your death.

Recurrent Disabilities

Once you have been disabled and have received Weekly Indemnity benefits under this Plan, a later disability will be defined as recurrent when it is separated from the previous one by less than two weeks of full-time or part-time employment at your usual place of employment. If your disability is classified as recurrent, it will be treated as a continuation of the previous disability. You will not have to resatisfy the waiting period and benefits will begin immediately.

In all instances, a disability will not be considered to be recurrent if it results from an injury or sickness, which is entirely unrelated to the cause or causes of the previous disability.

Exceptions and Limitations

Weekly Indemnity benefits are not payable for disabilities:

- for which the employee is not receiving appropriate treatment;
- resulting from self-inflicted injury or illness;
- resulting from insurrection, war, full-time service in the Armed Forces of any country (other than the Armed Forces Reserve), or participation in a riot;

- for which benefits are payable under any Workers' Safety and Insurance Act or similar legislation;
- occurring while you are on vacation for which you have received vacation pay; or
- resulting from cosmetic surgery or treatment, unless received for an accidental injury and commenced within 90 days of the accident.

Complications due to pregnancy are covered. However, any disability due to any cause will not be eligible for benefits at any time when you are on pregnancy or parental leave of absence or could be placed on such leave by MDA in accordance with relevant government legislation or by prior agreement with the Company.

Claims Procedures

Claim forms are available from your Human Resources Department. You and MDA complete certain portions of the form and your doctor completes the Attending Physician's Statement.

In order to be eligible for payment, Weekly Indemnity claims must be submitted within 90 days of the date disability began.

Long Term Disability Benefit

Long Term Disability insurance is underwritten by Great-West Life.

The Long Term Disability Plan provides income security should you become totally disabled and remain so over a long period of time while under the continuing care of a physician.

Definition of Total Disability

For the Long Term Disability Plan, "totally disabled" means that you are wholly and continuously disabled due to illness or accidental bodily injury and, as a result, you are unable to perform the duties of your normal occupation during the 52 week qualifying period and the succeeding 24 months. If, after this time, you are unable to perform the duties of any occupation for which you are or may become fitted by education, training or experience, you will still be considered totally disabled.

Confinement is not normally required. You must be under the regular care of a physician, however, and be prepared to attempt rehabilitative employment, or participate in a rehabilitation program considered appropriate by the insurance company and your doctor.

If you are temporarily assigned outside Canada at the time disability commences, you must return to Canada in order to be eligible to receive benefits.

If you must hold a government permit or license to perform your duties, you will not be considered totally disabled solely because such permit or license has been withdrawn or not renewed.

Long Term Disability Benefit

Your benefit will be 50% of your regular monthly earnings up to a maximum of $1,800 per month, reduced by certain other sources of income.

The amount of benefit described above will be reduced by other income to which you may be entitled from any of the following sources:

- Benefits under any government plan, law or agency for the same or a subsequent disability, excluding dependent benefits, Employment Insurance benefits and automatic cost-of living increases that occur after benefits begin;

- Benefits under any Workers' Compensation Act or similar law for the same or a subsequent disability, excluding automatic cost-of-living increases that occur after benefits begin;

- Benefits under motor vehicle insurance plan but only as long as the law does not prohibit such a deduction;

- Benefits under a group plan, including any coverage resulting from the employee's membership in an association of any kind;

- Benefits under a retirement or pension plan funded in whole or in part by the employer, as a result of a disability or medical condition; and

- Earnings or payment from any employer.

The benefit as calculated will be further reduced by any amount by which such benefit, when added to the income from all other sources outlined above (not including Canada/Quebec Pension Plan benefits payable to you on behalf of dependents), exceeds 50% of your regular pre-disability earnings.

If you might qualify for any of the benefits listed above, it is your responsibility to apply for them and to provide any additional documentation that might be needed to support your claim.

Commencement of Benefits

Benefits begin after a qualifying period of 52 weeks of uninterrupted total disability.

Maximum Benefit Period

Once you have satisfied the qualifying period, you will receive a monthly income as long as you remain totally disabled until the earliest of the following dates:

- The date you have received benefit payments equal to your number of months of seniority (calculated on the date disability commenced), minus 12 months;

- The end of the month in which you turn 65;

- The date you decline to participate in an approved rehabilitation program (see "Rehabilitation" below);

- The date of your death; or

- The date you are no longer considered totally disabled.

You may be requested to undergo a physical or mental evaluation or to submit proof of your ongoing disability. Failure to do so when requested may result in termination of your benefit payments.

Should you complete the qualifying period after your 64th birthday but prior to your 65th birthday, the monthly income payments will continue beyond age 65 until a total of 12 monthly payments have been made or total disability ceases, whichever occurs first.

Extension of Benefits on Termination of Employment

Subject to the maximum benefit period, Long Term Disability benefits will extend beyond your termination date provided you became disabled while you were still insured. Benefits will continue to be paid according to the group insurance contract provisions in effect at the time you started to receive LTD benefits.

The insurance company reserves the right to require that while you are in receipt of Long Term Disability income, you furnish proof of your continuing total disability and submit to an examination by one of their medical advisors when requested.

Rehabilitation

Long Term Disability benefits are designed to be paid during periods when you are disabled and cannot work. There may be times, however, when you are not yet fully recovered but you can work at some type of job and possibly earn an income. This type of work is usually considered to be "rehabilitative employment".

Your rehabilitative employment must be approved by both your attending physician and the insurance company, and may continue for up to two years. Participating in an approved program of rehabilitative employment does not affect your ability to qualify for Long Term Disability benefits as long as you are still "totally disabled" as defined above. On the other hand, if you decline to participate in an approved rehabilitation program while it continues to be recommended by your attending physician (for example, in situations involving substance abuse), you will cease to be eligible for Long Term Disability benefits.

Although most income is normally used to reduce Long Term Disability benefits, in the case of rehabilitative employment, earnings will not be used to reduce your Long Term Disability payments (provided that your income from all sources, including those outlined previously, is not greater than 100% of your gross earnings prior to your disability).

Recurrent Disabilities

Once you have been disabled and have received benefits under this Plan, a later disability will be defined as recurrent when it is separated from the previous one by less than 52 weeks of active employment.

A disability will not be considered to be recurrent if it results from an injury or sickness that is entirely unrelated to the causes of the previous disability.

If any period of disability is classified as "recurrent", it will be treated as a continuation of the previous disability. Then you will not have to resatisfy the 52 week qualifying period and benefits will begin again immediately.

Exceptions and Limitations

Long term disability benefits are not payable for any period that:

- You are not receiving appropriate treatment;
- You do any work for wages or profit, except as approved by Great West Life;
- You not participating in an approved partial disability or rehabilitation program, if required by Great West Life;
- You are residing outside of Canada; or
- You are serving a prison sentence or are confined in a similar institution.

Long term disability benefits are not payable for total disability resulting from:

- Intentionally self-inflicted injuries or illness;
- Insurrection, war, full-time service in the Armed Forces of any country (other than the Armed Forces Reserve), or participation in a riot; or

- Participation in a criminal offence.

Claims Procedures

Claim forms are available from your Human Resources Department. You and MDA complete certain portions of the form and your doctor completes the Attending Physician's Statement.

In order to be eligible for payment, Long Term Disability claims must be submitted not later than 12 months following the date disability began.

Canada / Quebec Pension Plan Disability Benefits

In the event that your disability results in a Long Term Disability claim, you may be eligible for CPP / QPP disability benefits. An application should be made for CPP / QPP disability benefits at the same time as you are applying for Long Term Disability. Claim forms are available from your local CPP / QPP office.