Cowan Insurance Group

CANADIAN COUNCIL *of* CHRISTIAN CHARITIES

EXPATRIATE INSURANCE PLAN

GROUP INSURANCE BENEFITS

FOR

Expatriates and their Dependents

Policy #158927CC

Effective date: April 1, 2017

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IMPORTANT INFORMATION

This material summarizes the important features of your group benefit plan. This booklet is prepared as information only and does not, in itself, constitute a contract. In the event of a discrepancy between this booklet and the master contracts governing the plan, those terms and conditions specified in the master contracts shall prevail. For further clarification on the terms and conditions of your group benefits please contact: clients@cowangroup.ca

The information contained in this booklet is important and it should be kept in a safe place.

GENERAL INFORMATION

ELIGIBILITY

You are eligible for coverage if you are under age 70 and working outside Canada (excluding the U.S), or working in Canada under terms that are approved by the plan administrator. Your country of posting is on record with the plan administrator, and is used by the assistance provider to validate claims submitted for consideration under the plan. If you change your country of posting, you must notify the plan administrator at least 15 days prior to the date of the change in your country of posting.

Your spouse and children who reside with you are eligible for dependent coverage while you are covered under this plan. Your spouse is a person under age 70 to whom you are married in a valid civil or religious ceremony, or with whom you now live and have publicly represented as your spouse and whose relationship with you has existed for at least 12 consecutive months prior to the date their coverage commenced. Your children are unmarried children born to, adopted by, or stepchildren of you or your spouse who are under age 21, or under age 25 if they are attending college or university as a full time student and dependent upon you for support and maintenance.

WHEN DOES COVERAGE COMMENCE

Coverage commences upon boarding the conveyance for departure from Canada to your country of posting, or at 12:01 a.m. local time on the date that coverage is scheduled to commence, whichever is later, unless otherwise approved in writing by the plan administrator. You must be actively at work or available for work on the date coverage commences. An eligible dependent hospitalized on the date your coverage commences will be covered only after having been discharged from hospital. If you are required to submit evidence of insurability for coverage requiring the completion of a health questionnaire, that coverage commences on the date approved by the insurer.

WHEN DOES COVERAGE CEASE

Coverage ceases upon disembarking the conveyance returning you to Canada from your country of posting, or at 12:01 a.m. local time on the date that coverage is scheduled to cease, whichever is earlier, unless otherwise approved in writing by the plan administrator. Coverage also ceases on the date your foreign assignment or employment ceases, you retire, the maximum age limit for coverage is reached, you or your dependent enters the armed services of any nation, your dependent is no longer an eligible dependent, one or more of the master contracts governing this plan terminates, or a required premium payment is due but not paid, whichever is earlier.

When you return to Canada on furlough, coverage will continue for up to 1 year only if your employer has approved the furlough and you are scheduled to continue your assignment thereafter. Coverage may continue beyond 1 year in special circumstances if approved in writing by the plan administrator.

When you return to Canada following the completion of your assignment all benefit coverage ceases, though Medical Benefits may continue upon written request by your employer if you are not covered by the Government Health Insurance Plan (GHIP) in your home province of residence. An application to reinstate GHIP coverage must be made within 10 days of arriving in Canada. Medical Benefits will continue, subject to all other terms and conditions, for the minimum residency period required to establish GHIP coverage in your home province of residence, though not beyond 100 days, at which time coverage ceases.

PROVISIONS UNDER THIS PLAN

Any inadvertent clerical error on the part of the plan administrator, employer, or insurer in maintaining or furnishing information shall not void any insurance coverage otherwise validly in force. If a person's age has been misstated, their true age will be used to determine the date coverage commences, the date coverage ceases, the amount of insurance, and other terms and conditions under this plan. The insurer, without restricting their right to do so and regardless of any other provision in this plan, because of fraud or material misrepresentation or non-disclosure, may void the insurance coverage of a person as if no coverage had ever been issued.

PLAN ADMINISTRATOR

All enrolment applications, claim submissions, and inquiries are to be directed to:

Cowan Insurance Group
Plan Administrator
700-1420 Blair Place
Ottawa, Ontario
K1J 9L8
Telephone: (613) 741-3313
Fax: (613) 741-7771
Toll Free: 1-888-509-7797
(Monday to Friday, 8:00 a.m. to 5:00 p.m.)
Email: clients@cowangroup.ca

CLAIMS

HOW TO CLAIM

eClaims: submit your claims using our mobile-friendly and secure member access site by visiting clients.cowangroup.ca. You must be signed up for direct deposit to utilize our eClaims tool.

Paper Claims: Completed claim forms, with itemized original statements or receipts (**not** photocopies), must be sent to:

Cowan Insurance Group
Plan Administrator
700-1420 Blair Place
Ottawa, Ontario
K1J 9L8

All claim payments issued will be in Canadian currency.

It is important to note that the certificate number appearing on your group insurance identification card must accompany all claims in order to avoid any delay of payment.

WHEN MEDICALLY NECESSARY CARE IS REQUIRED (EMERGENCY AND NON EMERGENCY)

Contact the assistance provider immediately upon admission to a hospital or clinic for treatment, before incurring any major medical expenses. A representative will answer the call to confirm coverage and guarantee payment to the service provider for eligible expenses. Failure to notify the assistance provider prior to incurring major expenses may reduce the reimbursement of eligible expenses by up to 50%, unless you are medically incapacitated and unable to do so.

If you require emergency medical evacuation, the assistance provider will arrange transportation and provide direct payment to the service provider. Your refusal to be transported, or failure to notify the assistance provider prior to incurring expenses, may result in unpaid claims and a loss of coverage.

Global Medical Assistance
Accessible 24/7
Call collect at 204-946-2577

Through an arrangement with an assistance company, Global Medical Assistance provides support worldwide to travelers in emergency medical situations and obtains Great West's approval for covered medical expenses. Some of their services may be restricted or unavailable in certain countries or regions due to war, civil unrest, political instability, and other factors beyond the control of the insurer and assistance provider.

If you are concerned with the availability or quality of care in your country of posting, call the assistance provider to explain the situation and request permission to travel. Limitations apply to expenses incurred while traveling outside your country of posting so it is imperative that you obtain prior approval from the assistance provider before traveling outside your country of posting for medical treatment.

ELIGIBLE EXPENSES

EMERGENCY AND NON-EMERGENCY EXPENSES

Eligible expenses as described in this section are medically necessary services at the location of posting and emergency services while on vacation or leave from the area of primary posting.

All services must be reasonable and customary, professionally recognized, medically necessary for the treatment of an injury or illness, and recommended or approved by a legally qualified physician/surgeon. Each practitioner must be legally qualified in the jurisdiction where the services were provided.

Reimbursement will be based on the usual, reasonable and customary charges for the area in which the expenses are incurred, less other amounts payable under any government health plan, private health plan, workers' compensation plan, credit card plan, or any other plan in effect at the time an expense is incurred.

No Deductible · 100% Reimbursement · $350,000 per Person Per Calendar Year

Semi-Private Hospital
Charges for inpatient intensive care and semi-private accommodation in a public general hospital, and for outpatient treatment and care in a public general hospital or clinic.

Convalescent Hospital
Charges for inpatient semi-private accommodation in a public convalescent hospital, occurring within 48 hours following a hospital stay of at least 5 consecutive days for the same cause, for up to 60 days per injury or illness, for a person under age 65.

Ambulance Services
Charges for ambulance travel by land, or by water or air when travel by land is not possible or feasible, to the nearest appropriate medical facility, or between facilities, inside or outside the country of posting.

Professional Services
Charges for professional medical and surgical services that are rendered by a legally and duly qualified physician, surgeon, and anaesthetist.

Medical Services
Charges for the diagnosis and treatment of an injury or illness, including laboratory and diagnostic tests, x-rays, and other medical services.

Obstetrical Care
Charges for uncomplicated childbirth expenses, and for complications arising out of pregnancy. The deliberate termination of a pregnancy is not an eligible expense.

Infant Child Care
Charges for in-hospital nursery expenses of a newborn, and for well-baby care expenses up to 6 months following the birth of a child, up to a maximum of $50,000.

Prescription Drugs
Charges for drugs and medicines requiring a prescription by law, syringes, and certain life sustaining non-prescription drugs, up to a maximum of $5,000. For diabetic supplies, including home chemical testing agents, eligible expenses are limited to a maximum of $1,000. For serums and vaccines immunizing against disease or poison, eligible expenses are limited to a maximum of $50 per treatment, which includes multiple injections of the same serum or vaccine if required to be administered in stages. The cost of administering injectable is not an eligible expense.

The dispensing of prescription drugs is limited to a 90 day supply, though in special circumstances, a longer supply may be eligible if approved in advance by the assistance provider.

Over-the-counter products, patent medicines, vitamins, first-aid supplies, oral and other contraceptives, smoking cessation products, anti-obesity drugs, infertility drugs, erectile dysfunction drugs, and experimental drugs are not considered eligible expenses.

Examinations
Charges for mammograms, which must be prescribed as medically necessary by a physician for a person under age 50, up to a maximum of $250, one routine health exam or check-up, up to a maximum of $150, and one eye exam, up to a maximum of $75 every 24 months, or 12 months for children under age 18.

Nursing Services
Charges for nursing services, prescribed as medically necessary by a physician, rendered in the home by a legally and duly qualified registered nurse, licensed practical nurse, or similarly qualified medical attendant, not normally a resident in your home nor related to you by birth or marriage, up to a maximum of $5,000.

Paramedical Services
Charges for paramedical services rendered by a legally and duly qualified psychiatrist or psychologist for 20 visits, up to a maximum of $1,000, and by a physiotherapist, chiropractor, osteopath, chiropodist, podiatrist, acupuncturist or speech therapist, up to a maximum of $500 per practitioner. The services of a legally and duly qualified midwife are also considered an eligible expense.

Accidental Dental
Charges for treatment required due to an accidental blow to the mouth, incurred within 12 months of the accident, to repair natural teeth including capped or crowned teeth, up to a maximum of $2,000.

Supplies & Equipment
Charges for the rental, or at the discretion of the insurer, the purchase of durable medical equipment such as manual hospital beds, crutches, canes, patient lifts, walkers, manual wheelchairs, casts, splints, slings, trusses, braces, bedpans, commodes, urinals, and oxygen.

Charges for myo-electric and standard external prosthetic appliances (but not dental appliances) that replace all or part of a body organ or the functions of a permanently inoperative or a malfunctioning body organ, if prescribed as medically necessary by a physician.

Charges for custom made boots or shoes, adjustments to stock item foot wear, orthopaedic shoes as an integral part of a brace, and custom made foot orthotics, if prescribed as medically necessary by a physician, up to a combined maximum of $300.

Charges for colostomy and ileostomy supplies, blood and blood products required for transfusions, radium and radioactive isotope, dialysis equipment, catheterization equipment, traction equipment, intermittent pressure units, neuromuscular stimulants, and heart monitors.

Charges for other medical supplies and equipment, if prescribed as medically necessary by a physician, may also be covered at the discretion of the insurer.

Emergency Travel Coverage
If during your assignment you travel outside your country of posting or return to Canada, whether on business or pleasure, eligible expenses are limited to unexpected and unforeseeable emergency medical expenses only, incurred within 30 days of departure from your country of posting. If you require coverage beyond 30 days, you must obtain prior approval from the plan administrator.

NOTIFICATION & PERMISSION TO TRAVEL

If you require medical treatment and you are concerned with the availability or quality of care in your country of posting, call the assistance provider to explain the situation and request permission to travel. The assistance provider must pre-approve travel for the purpose of receiving medical treatment, and specify in which country or region treatment may be obtained. Only expenses incurred in the specified country or region are eligible.

If you request and obtain permission to travel for medical treatment, travel and other non-medical costs are not considered eligible expenses. Only if the assistance provider deems that an emergency medical evacuation is required will these costs be considered for reimbursement under this plan.

Traveling for the purpose of receiving medical treatment is not permitted without prior approval. Failure to obtain prior approval may result in unpaid claims and a loss of coverage. If you relocate or travel to another country, in the opinion of the insurer, for the purpose of receiving medical treatment without prior approval, the insurer reserves the right to limit or deny claims and void your coverage.

SIGNIFICANT MEDICAL CONDITIONS

If you have or develop a significant medical condition that, in the opinion of the insurer, is likely to be prolonged, require ongoing treatment, and/or lead to further complications, the insurer reserves the right to require you to travel to Canada or any other place where appropriate treatment is available. Failure to comply will result in unpaid claims and a loss of coverage. Upon consideration of the circumstances, the insurer may provide advance notice of the requirement to travel, though is not required to do so. If you subsequently depart from where treatment is rendered without prior approval, coverage under this plan will automatically cease on that date.

After recovering from a significant medical condition, coverage under this plan may be continued if you are deemed by the insurer to be in good health, free of symptoms and unlikely to relapse. Contact the plan administrator in writing for continuing coverage requirements.

HOW TO HANDLE CLAIMS

You must contact the assistance provider for prior approval of all major expenses, including hospitalization, surgical services and nursing services. Failure to notify the assistance provider prior to incurring major expenses may reduce the reimbursement of eligible expenses by up to 50%. For services and supplies co-ordinated through the assistance provider, direct payment will be made to the service provider. If the provider refuses to accept guaranteed payment from the assistance provider, you may be required to pay for services and supplies and submit original paid receipts for reimbursement. Contact the assistance provider for instructions.

For services and supplies where you have incurred out-of-pocket expenses, you must submit original paid receipts to the address on the claim form no later than 12 months following the date the expense was incurred. Receipts must clearly show the name of the patient, dates, charges, and a detailed description of the expenses. Where appropriate, include the original written referral of a physician and all other supporting documentation for the claim. Claims converted to Canadian dollars will be processed at the rate of exchange on the date the expense was incurred.

LIMITATIONS & EXCLUSIONS

No benefits shall be payable for any loss caused by, as a result of, or connected with the following, even when recommended by a physician:

- Any treatment and care that is not medically necessary, that is deemed discretionary, elective, cosmetic or experimental, or that could reasonably be delayed until you return to Canada following the completion of your assignment. The purchase of eyewear or hearing aids is not an eligible expense.

- Any treatment and care in a chronic or psychiatric hospital, chronic unit of a hospital, long term care facility, nursing home or spa, treatment and care that you elect to receive, or any treatment and care rendered in a facility not approved by the insurer.

- Over-the-counter products, medicines that do not normally require a prescription, food and nutritional systems, information pamphlets and books, video instructional kits, delivery charges, nor any form of treatment and care for which there would be no charge in the absence of coverage or that is provided for use by a third party.

- Durable medical equipment unless appropriate for use in the home and generally not useful in the absence of injury or illness. If deluxe medical equipment is required, reimbursement will be made only if the deluxe features are required by the person to effectively operate themselves. Items that are not primarily medical, or are used for comfort and convenience, are not eligible expenses.

- The replacement of lost, missing or stolen items, or items damaged due to negligence. The replacement of durable equipment and prosthetic appliances are eligible due to natural wear, growth, or a change in medical condition, but only if the equipment or prosthetic appliance cannot be adjusted or repaired at lesser cost.

- A duplicate prosthetic device or appliance, or any device or appliance that is used solely for recreational or sporting activities.

- Participating in a riot or civil commotion, or any act of war or terrorism except as provided for by the War Risk & Terrorism provision under Contingency Benefits.

- Provoking, attempting, or committing a criminal offence, and any attempt at suicide or self-destruction or any form of self-inflicted injuries whether sane or insane.

- Any injuries or losses that are sustained while serving as a pilot or crewmember of any vehicle or device for aerial navigation. Coverage applies to passenger type aircraft operated by a licensed carrier, and transport type aircraft operated by the Canadian Armed Forces or similar transport service of another country. Under no circumstances shall benefits be paid where the aircraft is owned, leased, or rented by an employer or organization with whom you are working or under contract.

GOVERNMENT HEALTH COVERAGE

GOVERNMENT HEALTH COVERAGE IS IMPORTANT

If you have Government Health Insurance Plan (GHIP) coverage in your home province of residence, you should ensure that your GHIP coverage remains in effect for as long as possible by obtaining the maximum allowable extension period available. Rules regarding the extension of GHIP coverage vary by province. In some provinces, you may qualify for a GHIP extension of many months or years, or an indefinite period of time. Though you should apply for an extension of coverage before leaving Canada, you may be eligible to obtain an extension of coverage even if applying from outside Canada.

If you do not have GHIP coverage in your home province of residence, apply for a reinstatement of GHIP coverage as soon as possible. Rules regarding the reinstatement of GHIP coverage vary by province. In some instances, you may be able to obtain a reinstatement of coverage even if applying from outside Canada. If you are required to apply from within your home province, you should do so immediately upon returning to Canada, regardless of how long you plan to remain in Canada.

You should obtain written confirmation of coverage from the GHIP office in your home province of residence. Documentation must clearly show names and the period for which coverage applies. Contact or visit your GHIP office for information on how to extend or reinstate GHIP coverage.

PRIVATE HEALTH COVERAGE IS IMPORTANT

This is a private health plan, supported entirely by the premium payments of plan members like you. This plan supplements the GHIP coverage in your home province of residence, providing added financial security and a broader scope of coverage by insuring many expenses not covered by GHIP. Though this plan will cover eligible expenses incurred regardless of whether you have GHIP coverage, coordinating expenses with GHIP and recovering claim costs from other sources where possible reduces the claim costs charged to this plan, which in turn results in lower premium payments.

LIFE BENEFITS

COVERED LOSSES

In the event of a loss of life, you and your insured dependents are covered for the amount of Life Insurance on record with the plan administrator. In addition to the terms and conditions in the General Information section, the following also apply:

Optional Member & Spouse Life Insurance terminates when you and your spouse attain age 65 respectively. Child Life Insurance commences 24 hours after birth.

Employee Life Insurance · Spouse Life Insurance · Child Life Insurance
Optional Employee Life Insurance · Optional Spouse Life Insurance

Waiver of Premium
In the event that you become totally disabled prior to age 65, premium payments shall be waived after 6 months for all benefit amounts in effect on the date you became totally disabled. The waiver of premium ceases when you attain age 65, retire, or upon your death. To qualify for waiver of premium, you are required to return to Canada so the insurer can evaluate your medical condition. Refusal to comply will disqualify you from entitlement to waiver of premium.

Totally disabled means an injury or illness that prevents you from engaging in each and every occupation or employment for compensation or profit for which you are, or may become, reasonably qualified by education, training or experience.

Conversion Privilege
If you are under age 65 and cease to be employed, you and your spouse may be able to convert your Life Insurance coverage under this plan to an individual policy within 31 days without having to submit evidence of insurability. Contact the plan administrator for additional information.

LIMITATIONS & EXCLUSIONS

No amount of Optional Life Insurance coverage, nor any increase in the amount of Optional Life Insurance coverage, shall be paid as a result of suicide within 2 years of the date that the coverage, or an increase in the coverage, commences.

No benefits shall be payable for any loss sustained while serving as a pilot or crewmember of any vehicle or device for aerial navigation. Coverage applies to passenger type aircraft operated by a licensed carrier, and transport type aircraft operated by the Canadian Armed Forces or similar transport service of another country. Under no circumstances shall benefits be paid where the aircraft is owned, leased, or rented by an employer or organization with whom you are working or under contract.

HOW TO HANDLE CLAIMS

In the event of your death, benefits are payable to your beneficiary. In the event of your insured dependent's death, benefits are payable to you. To obtain claim forms and assistance in submitting claims, contact: clients@cowangroup.ca

ACCIDENT BENEFITS

COVERED LOSSES

In the event of a covered loss, you and your insured dependents are covered for the amount of Accidental Death & Dismemberment Insurance (AD&D) on record with the plan administrator. In addition to the terms and conditions in the General Information section, the following also apply:

Optional Member & Spouse AD&D Insurance terminates when you and your spouse attain age 65 respectively. Child AD&D Insurance commences 24 hours after birth.

Member AD&D Insurance · Spouse AD&D Insurance · Child AD&D Insurance
Optional Member AD&D Insurance · Optional Spouse AD&D Insurance

Table Of Losses
In the event of an accidental injury resulting in a covered loss, occurring within 365 days of the date of the accident causing such loss, the amount payable is a percentage of the principal sum for which the insured person is eligible. If more than one loss is sustained from the same injury, only one amount, the largest, shall be payable.

Quadriplegia, Paraplegia, or Hemiplegia 200%

Life, Entire Sight of Both Eyes, Both Speech and Hearing, Both Hands, Both Feet, Use of Both Arms, Use of Both Hands, One Hand and One Foot, One Hand and Entire Sight of One Eye, or One Foot and Entire Sight of One Eye..... 100%

One Arm, One Leg, Use of One Arm, or Use of One Leg 75%

One Hand, One Foot, Entire Sight of One Eye, Speech, Hearing, Use of One Hand, or Use of One Foot 67%

Hearing in One Ear, Thumb and Index Finger of the Same Hand, or Four Fingers of the Same Hand 33%

All Toes of One Foot 25%

Exposure & Disappearance
If a person is unavoidably exposed to the elements and suffers a covered loss as a result of such exposure, the loss will be deemed covered under the terms of this plan. If a person is not found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance upon which the person was an occupant, it will be deemed that the person has suffered an accidental loss of life under the terms of this plan.

Permanent Total Disability
If a person becomes totally and permanently disabled prior to age 65, the principal sum will be paid, less any amount that is paid under the Table Of Losses, provided the disability commences within 365 days of the accident and continues for 12 consecutive months. Totally and permanently disabled means an accidental injury deemed by the insurer to be total, continuous and permanent, which prevents the person from engaging in each and every occupation or employment for compensation or profit for which the person is, or may become, reasonably qualified by education, training or experience.

Waiver of Premium
If you qualify for the Life Insurance waiver of premium, all AD&D Insurance premium payments are waived for amounts in effect on the date you become totally disabled. Waiver of premium ceases on the date Life Insurance waiver of premium ceases, or earlier if this benefit or the policy terminates.

ANCILLARY BENEFITS

In addition to the benefits payable in the Table of Losses, the following ancillary benefits may also be payable if you or your insured dependent suffers a covered loss.

Rehabilitation Expenses
If a payment is made under the Table Of Losses for you or your spouse and special training is required to become qualified to engage in an occupation the person would not have otherwise been qualified, the insurer will pay reasonable and necessary expenses incurred within 2 years of the accident for such training, excluding ordinary living, travel, or clothing expenses, up to a maximum of $15,000.

Home & Vehicle Expenses
If a payment is made under the Table Of Losses and a wheelchair is required by the person to be ambulatory (due to the cause for which payment is made), the insurer will pay the one-time cost of home alterations to make it wheelchair accessible and habitable, and vehicle modifications to make it accessible or driveable, up to a combined maximum of $15,000.

Payment will be made only if the home alterations are performed by individuals experienced in such alterations and who are recommended by a recognized organization providing support and assistance to wheelchair users, and the vehicle modifications are performed by individuals experienced in such modifications and they are approved by government vehicle licensing authorities.

Spouse Training Expenses
If you suffer a loss of life as a result of an accident, the insurer will pay to or on behalf of your surviving spouse the actual costs charged within 30 months of the accident for any professional or trades training program that your spouse has become enrolled in for the purpose of obtaining an independent source of support and maintenance following your death, up to a maximum of $10,000.

Child Education Expenses
If you or your spouse suffer a loss of life as a result of an accident, the insurer will pay on behalf of a dependent child who is enrolled as a full time student in an institution of higher learning beyond the 12th grade, or is currently in the 12th grade and subsequently enrols within 365 days, the actual tuition costs charged by the institution, excluding room and board expenses, up to a maximum of $5,000 per year for up to 4 consecutive years while the child continues to be enrolled.

Child Day Care Expenses
If you or your spouse suffer a loss of life as a result of an accident, the insurer will pay on behalf of a dependent child under age 13 who is enrolled in an accredited day care centre, or who subsequently enrols within 90 days, the actual child care costs charged by the centre, up to a maximum of $5,000 per year for up to 4 consecutive years while the child continues to be enrolled.

In-Hospital Expenses
If you or your spouse is hospitalized for more than 7 consecutive days as a result of an accident, the insurer will pay $50 per day for each full day of continuous hospital confinement, retroactive to the first day of such confinement, up to a maximum of $1,500.

Seat Belt Enhancement
An amount payable under the Table Of Losses shall be increased by 10% if injury or death results while a driver or passenger of a private passenger type automobile with the seat belt properly fastened. Verification of the use of the seat belt must be part of the official accident report or certified by the investigating officer.

LIMITATIONS & EXCLUSIONS

No benefits shall be payable for any loss caused by, as a result of, or connected with the following:

- Participating in a riot or civil commotion, or any act of war or terrorism except as provided for by the War Risk & Terrorism provision under Contingency Benefits.

- Provoking, attempting, or committing a criminal offence, and any attempt at suicide or self-destruction or any form of self-inflicted injuries whether sane or insane.

- Any form of illness or disease that is not solely and directly resulting from an accidental external blow to the body, including but not limited to, heart attack or stroke.

- Any injuries or losses that are sustained while serving as a pilot or crewmember of any vehicle or device for aerial navigation. Coverage applies to passenger type aircraft operated by a licensed carrier, and transport type aircraft operated by the Canadian Armed Forces or similar transport service of another country. Under no circumstances shall benefits be paid where the aircraft is owned, leased, or rented by an employer or organization with whom you are working or under contract.

HOW TO HANDLE CLAIMS

In the event of your death, benefits are payable to your beneficiary. All other benefits, including those for your insured dependents, are payable to you. To obtain claim forms and assistance in submitting claims, contact: clients@cowangroup.ca

You must contact the assistance provider for prior approval of all major expenses, including rehabilitation expenses and home and vehicle modifications. Failure to notify the assistance provider prior to incurring expenses may reduce the reimbursement of eligible expenses by up to 50%. For services and supplies co-ordinated through the assistance provider, direct payment will be made to the service provider. If the provider refuses to accept guaranteed payment from the assistance provider, you may be required to pay for services and supplies and submit original paid receipts for reimbursement. Contact the assistance provider for instructions.

For services and supplies where you have incurred out-of-pocket expenses, you must submit original paid receipts to the address on the claim form no later than 12 months following the date the expense was incurred. Receipts must clearly show the name of the patient, dates, charges, and a detailed description of the expenses. Where appropriate, include the original written referral of a physician and all other supporting documentation for the claim. Claims converted to Canadian dollars will be processed at the rate of exchange on the date the expense was incurred.

CONTINGENCY BENEFITS

WAR RISK & TERRORISM

Coverage under this plan includes losses resulting from an act of war, terrorism or insurrection, but only in unexpected, unforeseeable and unavoidable circumstances. Coverage does not apply if you intentionally place yourself in harm's way, or you remain or travel into a hostile area within a country or region that, in the opinion of the insurer, constitutes an unreasonable risk to personal safety, and in such incidents, the insurer reserves the right to limit or deny claims for injuries or losses.

In the event of an outbreak of armed conflict between nations, tribes or other factions, or the overthrow of government in your country of posting resulting in a direct threat to personal safety due to political instability, coverage is extended for a maximum of 10 days to allow sufficient time to find a means of safe departure from the country or region. If you are medically incapacitated or forcibly detained before your departure is possible, coverage under this plan will automatically be extended until the date that you return, or are able to return, to Canada.

You are required to exercise reasonable caution and prudence in hostile areas. It is your responsibility to adhere to travel advisories and reports that are issued by the Government of Canada, and regularly updated, for the country or region to which you are posted, or plan to visit, during your assignment.

ANCILLARY BENEFITS

These ancillary benefits provide you with an added layer of protection. Contact the assistance provider to coordinate the following, prior to incurring any expenses.

Repatriation Expenses
If a person suffers a loss of life as a result of an accident occurring more than 200 kilometres from their city of permanent residence, the insurer will pay actual expenses incurred for the cost of preparation, including cremation, and homeward transportation of the deceased to their city of permanent residence for burial, up to a maximum of $15,000. If you elect a local burial or cremation, expenses are limited to $3,000. Coverage excludes the cost of a burial coffin.

Medical Evacuation
If the insurer deems that a person must return to Canada due to a medical emergency, or be moved to another place where appropriate treatment is available, the insurer will pay the cost of one way economy airfare, plus the cost to accommodate a stretcher, to travel by the most direct route to the intended destination. For children under age 18 that must be accompanied by a parent or guardian, reimbursement for Family Transportation and Meals & Accommodation costs are also considered eligible expenses.

If the insurer or airline deems that a person must be accompanied by a qualified medical attendant, coverage includes the cost of round trip economy airfare and the usual and customary fee charged by an attendant who is registered in the jurisdiction and not a relative by birth or marriage, plus overnight Meals & Accommodation costs.

The insurer reserves the right to return you to Canada, or to move you from one medical facility to another, whether the move occurs inside or outside your country of posting. If the insurer moves you temporarily to another country for treatment, and you recover fully, the insurer will pay the cost of one way economy airfare to return you to your county of posting, but only if deemed appropriate and approved by the insurer.

Child Evacuation
If you or your spouse suffer a loss of life or are hospitalized for more than 10 days, and your children under age 18 are left unattended, the insurer will pay the cost of one way economy airfare for each child to travel by the most direct route to the air terminal nearest their home city of residence. The insurer may consider another country if the children are to be cared for by a person who is not a resident of your home country.

If the insurer or airline deems that a child must be accompanied by a qualified child care attendant, coverage includes the cost of round trip economy airfare and the usual and customary fee charged by an attendant who is registered in the jurisdiction and not a relative by birth or marriage, plus overnight Meals & Accommodation costs.

Family Transportation
If you are confined to a hospital more than 200 kilometres from your city of permanent residence and you are not accompanied by a family member or companion age 18 or older, the insurer will pay the cost of round trip economy airfare by the most direct route for a family member or companion age 18 or older to travel to your bedside. To be considered an eligible expense, you must eventually be confined as an in-patient for at least 7 days and receive written verification from the attending physician that the situation was serious enough to warrant the visit. Reimbursements for Meals & Accommodation costs are also considered eligible expenses.

If you suffer a loss of life and you are not accompanied by a family member or companion age 18 or older, the insurer will pay the cost of round trip economy airfare by the most direct route for a family member or companion age 18 or older to identify your mortal remains prior to the release of the body. Reimbursements for Meals & Accommodation costs are also considered eligible expenses.

Meals & Accommodation
If you or a companion with whom you are traveling suffer a loss of life or are hospitalized, interrupting or delaying a trip excursion in progress, reimbursement will be made for the cost of commercial meals and accommodation expenses incurred while remaining with the deceased or hospitalized person, for up to 10 days, up to a combined maximum of $200 per day.

Temporary Child Care
If you or your spouse suffer a loss of life or are hospitalized for more than 3 days, and your children under age 18 are left unattended, reimbursement will be made for the cost of a qualified child care attendant who is registered in the jurisdiction and not a relative by birth or marriage, to care for your children for up to 10 days, up to a maximum of $200 per day. For hospital confinement, coverage is retroactive to the first day of confinement.

Return Of Vehicle
If you or your spouse suffer a loss of life or are hospitalized for more than 3 days, and as a result unable to return your private or rental vehicle to your residence or rental agency, the insurer will pay the cost of returning your vehicle using a commercial agency, up to a maximum of $3,000.

Loss Of Vehicle
If your private or rental vehicle is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of one way transportation by public conveyance, for you and occupants in the vehicle, for immediate local travel to your residence, rental agency, or intended destination, up to a combined maximum of $500.

LIMITATIONS & EXCLUSIONS

No benefits shall be payable for any loss caused by, as a result of, or connected with the following, even when recommended by a physician:

- Participating in a riot or civil commotion, or any act of war or terrorism except as provided for by the War Risk & Terrorism provision under Contingency Benefits.

- Provoking, attempting, or committing a criminal offence, and any attempt at suicide or self-destruction or any form of self-inflicted injuries whether sane or insane.

- Any injuries or losses that are sustained while serving as a pilot or crewmember of any vehicle or device for aerial navigation. Coverage applies to passenger type aircraft operated by a licensed carrier, and transport type aircraft operated by the Canadian Armed Forces or similar transport service of another country. Under no circumstances shall benefits be paid where the aircraft is owned, leased, or rented by an employer or organization with whom you are working or under contract.

HOW TO HANDLE CLAIMS

You must contact the assistance provider for prior approval of all major expenses, including repatriation, evacuation and travel expenses. Failure to notify the assistance provider prior to incurring expenses may reduce the reimbursement of eligible expenses by up to 50%. For services and supplies co-ordinated through the assistance provider, direct payment will be made to the service provider. If the provider refuses to accept guaranteed payment from the assistance provider, you may be required to pay for services and supplies and submit original paid receipts for reimbursement. Contact the assistance provider for instructions.

For services and supplies where you have incurred out-of-pocket expenses, you must submit original paid receipts to the address on the claim form no later than 12 months following the date the expense was incurred. Receipts must clearly show the name of the patient, dates, charges, and a detailed description of the expenses. Where appropriate, include the original written referral of a physician and all other supporting documentation for the claim. Claims converted to Canadian dollars will be processed at the rate of exchange on the date the expense was incurred.

DISABILITY BENEFITS (if applicable)

Important Note: Coverage under this benefit applies only when your employer has arranged coverage on your behalf. If you are unsure as to whether or not you are covered under this benefit, contact your employer or the plan administrator for confirmation of coverage.

COVERED LOSSES

In the event of disability, you are covered for the amount of Long Term Disability Insurance on record with the plan administrator. In addition to the terms and conditions in the General Information section, the following also apply:

Long Term Disability Insurance terminates when you attain age 65 less the elimination period.

Long Term Disability Insurance

Benefit Amount
The benefit amount is calculated at 60% of your gross monthly earnings, rounded to the next higher multiple of $1 unless already a multiple thereof. If your employer pays any portion of the premium for your Long Term Disability benefit, the benefit payments are taxable.

Payments Commence
Benefit payments commence following the elimination period, and are paid while you remain totally disabled, up to age 65. The elimination period is a continuous 119 day period of disability that you must satisfy in order to qualify for benefits, starting on the first day that you become totally disabled. To qualify for benefit payments under this plan, you are required to return to Canada so the insurer can evaluate your medical condition. Refusal to comply will disqualify you from entitlement to benefit payments.

Totally Disabled
Totally disabled means an injury or illness that prevents you from engaging in each and every duty of your own occupation during the elimination period and the following 24 months; and thereafter, that prevents you from engaging in each and every occupation or employment for compensation or profit for which you are, or may become, reasonably qualified by education, training or experience.

Benefit Reductions
Benefit payments under this plan shall be reduced by any amounts that you receive, or are entitled to receive, from the Canada Pension Plan or Quebec Pension Plan, any government plan benefits, any automobile insurance plan, or for which you are or may become entitled to receive from a third party as compensation for loss of income. Your benefits will be further reduced by any amounts that you receive, or are entitled to receive, as employment income or wages, severance or similar compensation, and disability benefits under any other group or association plan, so that your total income from all sources does not exceed 85% of pre-disability earnings.

Payments Cease
Benefit payments under this plan cease on the earlier of the date that you are no longer totally disabled or receiving ongoing care from a physician, you fail to provide proof of continuing disability, you refuse to participate in a rehabilitation program, you begin working in any occupation, you attain age 65, you retire, or upon your death.

Recurrent Disability
If you return to active full time employment after benefits become payable and become totally disabled again due the same cause or a related cause within 6 months, the disability is considered a recurrent disability and benefit payments will recommence on that date. If you suffer a recurrent disability after 6 months, or you become totally disabled at any time due to an unrelated cause, you are required to satisfy a new elimination period.

Rehabilitation
If you become totally disabled, you may be required to participate in a suitable rehabilitation training program that takes into account both the nature and limitations of your disability, and assists in your return to gainful employment. Financial incentives may be provided to you during rehabilitation.

Waiver of Premium
If you become totally disabled prior to age 65, premium payments shall be waived while you receive disability benefit payments. If you return to active full time employment, premium payments shall again become due on the date you return to work.

LIMITATIONS & EXCLUSIONS

No benefits are payable if you become totally disabled within 12 months of the date that your coverage commences if caused by, attributed to, or in connection with any injury or illness for which you received medical consultation, treatment or care, or were prescribed medication in the 6 month period prior to the date coverage commences.

No benefits shall be payable for any period of disability caused by, as a result of, or connected with the following:

- Participating in a riot or civil commotion, or any act of war or terrorism except as provided for by the War Risk & Terrorism provision under Contingency Benefits.
- Provoking, attempting, or committing a criminal offence, and any attempt at suicide or self-destruction or any form of self-inflicted injuries whether sane or insane.
- Any period in which you are not receiving appropriate and treatment and care from a physician, or your refusal to participate in an appropriate rehabilitation program.
- Any period in which total disability commences or occurs during a leave of absence, other than during the continuation of coverage for a maternity or parental leave of absence as required by law, or in a written agreement between you and your employer.
- Any injuries or losses that are sustained while serving as a pilot or crewmember of any vehicle or device for aerial navigation. Coverage applies to passenger type aircraft operated by a licensed carrier, and transport type aircraft operated by the Canadian Armed Forces or similar transport service of another country. Under no circumstances shall benefits be paid where the aircraft is owned, leased, or rented by an employer or organization with whom you are working or under contract.

HOW TO HANDLE CLAIMS

If you become totally disabled and it is possible you will remain disabled beyond the elimination period, send written notification to your employer and the plan administrator within 30 days. Early notification is required by the insurer, and will help to ensure your claim is processed quickly. In order to qualify for benefit payments, you are required to return to Canada so the insurer is able to evaluate your medical condition. To obtain claim forms and assistance in submitting claims, contact: clients@Cowangroup.ca

DENTAL BENEFITS (if applicable)

Important Note: Coverage under this benefit applies only when your employer has arranged coverage on your behalf. If you are unsure as to whether or not you are covered under this benefit, contact your employer or the plan administrator for confirmation of coverage.

ELIGIBLE EXPENSES

If you or your insured dependent requires dental treatment, the following are considered eligible expenses.

No Deductible · 100% Reimbursement · $1,000 per Person Per Calendar Year

Reimbursement will be based on the usual, reasonable and customary charges for the area in which the expenses are incurred, less amounts that are payable under any government health plan, private health plan, workers' compensation plan, credit card plan, or any other plan in effect at the time an expense is incurred. For services rendered in Canada, coverage is based on the current fee schedule where services are rendered. For services rendered outside Canada, coverage is based on the current Ontario fee schedule. The insurer reserves the right to make a determination of benefits taking into account alternate treatment based on accepted dental standards.

Diagnostic Services
Charges for procedures to evaluate the need for treatment, including x-rays, study casts, biopsies, and laboratory examinations required to diagnose a specific condition.

Preventive Services
Charges for cleaning, scaling, polishing and fluoride once every 6 months, and for children under 15, pit and fissure sealants and space maintainers to replace lost teeth.

Restorative Services
Charges for procedures used to restore natural teeth through the use of amalgam, tooth coloured filling restorations, temporary sedative fillings, and inlay restorations.

Extraction Services
Charges for simple and complicated removal of erupted teeth, partially or completely bone impacted teeth, extra teeth, teeth in an unusual position, and residual roots.

Endodontic Services
Charges for procedures in connection with root canal therapy, including root resections and amputation, and emergency procedures to open or drain the gum or tooth.

Periodontic Services
Charges for procedures used to treat the bones and gums, including scaling and root planning, grafts using the patient's own tissue, and certain periodontal appliances.

Denture Services
Charges for denture adjustments, remounts and equilibration procedures, remake of a partial denture using existing framework, repairs and the addition of teeth, standard relining and rebasing once every 3 years, cleaning once every 9 months, and soft tissue conditioning linings to promote healing.

Surgical Services
Charges for removal of cysts and tumours, the reposition or transplantation of teeth, treatment of a dislocation and/or fracture of the upper or lower jaw, the repair of soft tissue lacerations, and general anaesthetics and intravenous sedation required in connection with eligible expenses under this plan.

LIMITATIONS & EXCLUSIONS

No benefits shall be payable for any loss caused by, as a result of, or connected with the following, even when recommended by a dentist:

- Any treatment and care that is deemed cosmetic, tooth implantation and the insertion of fabricated implants, and appliances for the treatment of myofacial pain syndrome.
- Participating in a riot or civil commotion, or any act of war or terrorism except as provided for by the War Risk & Terrorism provision under Contingency Benefits.
- Provoking, attempting, or committing a criminal offence, and any attempt at suicide or self-destruction or any form of self-inflicted injuries whether sane or insane.

HOW TO HANDLE CLAIMS

For services and supplies where you have incurred out-of-pocket expenses, you must submit original paid receipts to the address on the claim form no later than 12 months following the date the expense was incurred. Receipts must clearly show the name of the patient, dates, charges, and a detailed description of the expenses. For claims incurred outside North America, include a written explanation of the dental treatment and all other supporting documentation for the claim. Claims converted to Canadian dollars will be processed at the rate of exchange on the date the expense was incurred.

In cases of any discrepancy between this booklet and the group policy, the policy shall prevail.