Manulife

The Manufacturers Life Insurance Company (Manulife)

FlexCare™ Health and Dental Plan

You've made a great choice to buy supplemental health care coverage with Manulife. This document contains all details about your policy and how to use it. Your contract includes this policy document, *Schedule of Benefits*, attachments, and any amendments. The effective date, also known as the start date, of this policy appears on the *Summary of Information* page. Read this document carefully to become familiar with the features of your policy so you can take full advantage of the benefits it offers.

Benefits are provided by The Manufacturers Life Insurance Company (Manulife). We administer this policy and pay benefits according to the terms, conditions, and limitations of the policy for as long as the premiums are paid. The first premium payment is due before the start date and future premiums are paid on the date shown on your *Summary of Information* page.

This policy contains a provision removing or restricting the right of the insured to designate persons to whom or for whose benefit insurance money is to be payable.

Signed for The Manufacturers Life Insurance Company (Manulife) at Toronto by:

Roy Gori,
President and Chief Executive Officer

30-day satisfaction guarantee

The first 30 days of your policy are known as the free-look period. If you decide that you don't want your policy, simply notify us.

We'll cancel your policy and send you a full refund, minus the Vitality charge and any claims we've paid. If the claims we paid are more than your premium payments, you must repay the difference. This right of cancellation expires 30 days after the policy is received by you and doesn't apply to any reissued, substituted or consolidated policy continuing coverage that started under a previously issued policy. The rights of any beneficiary under the policy are also subject to this right of cancellation.

The Manufacturers Life Insurance Company
Individual Insurance
P.O. Box 670, Station Waterloo,
Waterloo, Ontario N2J 4B8
1 800-268-3763– manulife.ca

Table of contents

Before you begin

This policy is a legal contract between you and us. In this policy, "you," "your" and "the insured" mean the owner of the policy, or any insured person. "We," "our," "us" and "the insurer" mean The Manufacturers Life Insurance Company (Manulife).

To be eligible to submit claims, you must pay the policy premiums in full to the current date, so your policy is in good standing. You must be a resident of Canada and have government health insurance coverage in your home province or territory.

We occasionally use the phrase "according to the terms and conditions of this policy." We may update our terms and conditions without notice to reflect corporate policies, economic changes, or legislative changes, including changes to income tax legislation. Any changes we make to the terms and conditions may affect the benefits provided by this policy.

All benefits outlined in this policy apply to each insured person. We only cover usual, reasonable and customary expenses for medically necessary conditions. This policy contains exclusions, limitations, conditions, deductibles, maximums and definitions. Please read it carefully.

Please note: Some of the terms used in this policy have been assigned a specific meaning. Refer to the section **Terms used in this policy** to familiarize yourself with these terms and their associated meaning whenever consulting this policy.

Coverage under this policy is only available to residents of Canada.

1 How your policy works

When you bought this health and dental care policy, we agreed to provide you with benefits according to the terms of this policy if you pay your premiums. All amounts payable under this contract either to or by us is payable in Canadian currency and don't earn interest. On the *Summary of Information* page, we show your effective date. This is also known as the policy start date.

Everyone insured under your policy has the same coverage.

Eligibility

To be eligible for coverage under this policy, you must meet all the following requirements:

- be a resident of Canada,
- have coverage under your government health insurance plan,
- Quebec residents must also be registered under the RAMQ Prescription Drug Insurance Plan or have equivalent coverage under a group plan, and
- be at least 18 years of age on the date of application for this policy, except for children of an insured person.

If we decide that you or anyone else on the policy was or is not eligible, we may: cancel the entire policy, modify it, or cancel only the coverage of the ineligible individuals. We'll maintain coverage for the remaining individuals insured under the policy, provided they aren't obligated to continue coverage in this manner. Premiums may not be returned, and we may also ask you to repay us for any claims paid after we told you about terminating your policy.

Premiums

The premium is the amount we charge you for your health care policy. The first premium payment is due before the effective date.

The premium changes if you change your coverages or if the coverage you chose has an increase on a scheduled renewal date. We'll send you a notice when your premium is scheduled to change.

The first premium payment is due before the effective date and then each monthly payment is due on a date determined by us. You can pay your monthly premiums automatically from your bank account or credit card. Payments must be in Canadian dollars, drawn from an account at a Canadian financial institution.

Your policy remains active from month to month if the required premiums are paid when due. If you don't pay your premiums, you have a 31-day grace period to pay the overdue amount to maintain your policy. Coverage ends on the last day of the grace period if we don't receive your payment. If a payment is returned because of insufficient funds, we charge a $25 administration fee.

We reserve the right to change premiums required for this policy. If we do, we'll give you 30 days notice. The premium may also change from year to year, depending on the Vitality Status™ of the primary insured.

How to change or cancel your policy

As your life changes, your policy can change with you. You can add or remove your spouse or children from your policy by notifying us online or in writing. We may require medical evidence when you add people to your coverage after the initial application. We don't require evidence of health for a newborn child if you send us the application within 30 days following the date of birth. Only one spouse may be covered under a plan at any given time.

You must have been covered under this policy for at least 12 consecutive months before you can change your benefits.

If you choose to change or end your coverage, you must contact us online or call our customer service centre at 1-800-268-3763.

The primary insured must remove an insured person under the plan if:

- they die,
- they are no longer a spouse of the primary insured due to divorce, or termination of a civil union in Quebec,
- their primary residence is different than the primary insured's, or
- an insured child turns 21, gets married, becomes an orphan, or obtains full-time employment.

Persons previously insured on your policy have the option to convert to their own policy if you contact us within 30 days of coverage cancellation. We'll provide you with a revised *Summary of Information* page to show the change to your policy and your new premium payment. If a cancellation isn't reported to us until after the expiry of this 30-day period, any refund of premiums paid on account of deceased or ineligible insured people is limited to a maximum of 12 months.

Any adult insured or dependent wishing to exercise their conversion right may also join the Manulife *Vitality*™ program at the time they apply for conversion, but not after. Vitality charges are not refundable.

You can't change the primary insured person, also known as the policy owner, to another person.

Reapplication

Twenty-four months must pass after a policy cancellation before another application is eligible under any Manulife individual (non-group) health plan.

How to contact us

You can send us notices, cancellations and documents online. Go to the website: manulife.ca/secureserve and click on **Contact us**.

You can also send any documents to us by prepaid post to:

Manulife, Individual Insurance
P.O. Box 670, Station Waterloo
Waterloo, ON N2J 4B8
Attention: Policy Service Department

When is a Prior Authorization form needed?

Before purchasing any product or service exceeding $300, you must send us a Prior Authorization form that outlines the purchase, lease, and rental charges for the equipment. We'll review the estimate and determine the amount payable, if any. We may make recommendations for services in your area.

You must send us a Prior Authorization form, signed by a medical professional, before you buy or arrange for these products or services:

- oxygen
- standard non-electric wheelchair
- hospital adjustable bed
- homecare or nursing
- hearing aids
- prosthetic appliances
- orthotics
- any medical equipment and supplies
- accidental dental

How to submit a Prior Authorization form

After you complete all sections and the physician, nurse practitioner, and vendor representative have added their comments, you can scan the form and send it online using our secure inbox at manulife.ca/secureserve.

If mailing the form, please keep a copy for your files. Original copies of forms or receipts won't be returned. Send the completed form to:
Manulife Individual Insurance,
Health Claims Prior Authorization,
P.O. Box 670, Station Waterloo,
Waterloo Ontario N2J 4B8.

We'll notify you of the approval limit of your request by email or mail. Please include your approval notice and complete vendor invoice indicating proof of applicable provincial or territory funding to your reimbursement claims submission online or by mail.

2 How we pay claims

When you bought this extended health care policy, we agreed that if you pay your premiums, we will provide you with insurance coverage according to the terms and conditions of this policy. Your health care benefits are specific to the plan coverage options you chose. Refer to your *Summary of Information* page for details of your coverage and your *Schedule of Benefits* for a list of coverages, reductions, limitations and exclusions.

We'll pay for eligible expenses by direct deposit or cheque to the policy owner or a service provider within 60 days. If the policy owner dies, we pay the claims to the owner's estate.

If you have eligible expenses for care, services or supplies as described in this policy, or a sickness, injury or other loss for which benefits are payable, we process and pay for claims that:

- happened within the last 12 months.
- are considered to be usual, reasonable and customary as determined by us. This means that the expenses can't be higher than the standard fee charged by providers of similar standing in the same geographical area, when providing the same treatment.
- are within the maximums of your policy.
- are determined medically necessary by us and are prescribed by a physician, nurse practitioner, dentist, denturist, or other licensed health care professional.
- are payable according to law.

We won't pay claims for:

- expenses that happen outside your home province or territory,
- benefits available through a government health insurance plan,
- expenses that aren't payable according to any exclusions, limitations, conditions, and amendments to this policy,
- services or supplies payable or available, regardless of any waiting list, under any government-sponsored plan or program unless explicitly covered under this benefit,
- prescription drugs, services, or supplies that aren't approved by Health Canada or another government regulatory body,
- services, supplies or treatment that aren't generally recognized by the medical profession in Canada as appropriate, effective, or required for the treatment of an accident, injury or illness in accordance with Canadian medical standards, or
- services, supplies, devices, or items that don't qualify as medical expenses under the *Income Tax Act (Canada),* unless covered under this policy.

3 Health care benefits

The following is a description of the health care benefits available under this policy. Benefits are subject to the limitations, exclusions and reductions of coverage which may appear in the description of a benefit, under a separate heading, or in the *Schedule of Benefits*. All benefits described in this part of the policy may not be applicable to your specific coverage. Please refer to your *Schedule of Benefits* and Manulife *Vitality* program summary, if applicable for details of coverage selected. Your participation in available manufacturer's rebate programs and government programs is mandatory for all applicable benefits. **The expense must occur in your home province or territory to be eligible.**

The service provider may not be your immediate family member. Service fees are considered up to the usual, reasonable and customary charges for each service. Payments for care, services or supplies in this section are subject to the maximum amounts stated in the *Schedule of Benefits* for this policy.

Extended health care benefit

Accidental dental

Charges for dental treatment of natural teeth required as a result of an accidental injury to the head or mouth and not by an object placed wittingly or unwittingly into the mouth. Applies only to injuries sustained after the policy start date.

You must:

- get approval from us before you begin any treatment, except for emergency treatment, to alleviate pain. Charges not reimbursed are your responsibility.
- send us a written estimate from the attending dentist, containing details of the accident, pre-accident condition of the teeth, planned treatment and cost. This is also known as a pre-determination of benefits.
- notify us of the injury within 90 days from the date of the accident.
- notify us if the insured is less than 18 years of age at the time of the accident, before that person reaches age 19.
- ensure the treatment begins within 90 days and ends within 1 year from the date of the accident.

We'll review the estimate and advise you of the amount of the benefit payable. We also:

- pay benefits in accordance with the *Dental Association Suggested Fee Guide for General Practitioners*, effective on the date of treatment in your province or territory of residence.
- determine the payable amount when a range of fees, laboratory charges or other individual considerations are included.

We won't pay for expenses that happen after the cancellation of either this policy, or coverage for an insured person listed on the policy.

We reserve the right to consider alternative procedures, services, courses of treatment and materials, and to provide benefits based on the least costly approach which would produce a professionally adequate result, consistent with accepted standards of dental practice. The fact that a similar procedure, service, course of treatment or material may have been previously used has no bearing on this provision. We also reserve the right to refuse reimbursement if a treatment plan isn't approved before the dental work is done.

Ambulance services

We'll pay the difference in amount between the government health insurance plan allowance and usual, reasonable, and customary charges for medically necessary professional ground and air emergency ambulance transportation within your home province or territory to a hospital. There is no lifetime maximum. We don't pay for private ambulance services to a hospital or ambulance services from a hospital to a residence or retirement home.

Diagnostic services – Quebec residents only

Charges for these diagnostic services:

- CAT scans
  Where required for the diagnosis or treatment of an illness or injury, when prescribed or requested by the attending physician or nurse practitioner.
- Ultrasound scans
  Where performed in a private clinic or office.
- Magnetic Resonance Imaging (MRI)
  Where required for the diagnosis or treatment of an illness or injury, when prescribed or requested by a physician or nurse practitioner.
- Laboratory tests
  Blood tests recommended by a physician or nurse practitioner and rendered by a nurse in a private medical clinic, laboratory, pharmacy or in home, urine tests and throat cultures where performed in a private clinic, which result from an accident or for the diagnosis or treatment of an illness, up to the overall maximum amounts payable per category.
- Prostate Specific Antigen (PSA) test
  Where required for the diagnosis or treatment of an illness, when prescribed or requested by the attending physician or nurse practitioner.

- CA 125 test
  Where required for the diagnosis or treatment of an illness, when prescribed or requested by the attending physician or nurse practitioner.
- Audiologist
  Charges for the services of an audiologist.

Hearing aids

Charges for hearing devices must be processed through government assistive devices programs (ADP) first and then sent to us. You must submit a Prior Authorization form, signed by a medical professional. Benefits are payable up to the maximum amount specified in your *Schedule of Benefits* and include the initial cost of batteries and repairs to hearing aids.

Exclusions – benefits aren't payable for:

- medical examination, audiometric examination, or hearing evaluation tests; or
- replacement batteries.

Homecare and nursing

Charges for the services of a:

- Registered Nurse (R.N.), Registered Practical Nurse (R.P.N.), Licensed Practical Nurse (L.P.N.), or Personal Support Worker, or
- Occupational Therapist.

Services must include substantive elements of personal care, be certified as medically necessary and can only be done in your primary residence to be eligible. You must send us a Prior Authorization form, signed by a physician or nurse practitioner. We'll advise you of the approval for the type of caregiver and duration of eligible services. For urgent and immediate needs, contact our call centre at 1-800-268-3763.

Exclusions: – benefits aren't payable for:

- agency fees, commissions, overtime charges or amounts that are more than usual, reasonable and customary charges as determined by us.
- services provided by a family member.
- services not authorized in writing by the attending physician or nurse practitioner.
- expenses that qualify for similar coverage under a government homecare program.
- meals and housekeeping, custodial care.
- respite, services in a hospital or long-term care facility, chronic care unit, slow stream rehabilitation centre.
- supervision, monitoring, shopping, transportation to and from the home or medical practitioner, and a live-in caregiver.

Medical equipment, prosthetics, and diabetic supplies

Before purchasing medical equipment and supplies, prosthetics, and diabetic supplies exceeding $300, you must send us a Prior Authorization form that outlines the purchase, lease, and rental charges for the equipment. We'll review the estimate and determine the amount payable, if any.

If the total cost of renting the equipment for the length of time the physician or nurse practitioner expects you to use it exceeds the price to purchase the equipment, we may choose to pay the initial purchase price for the item instead of rental charges for these items:

- standard non-electric wheelchairs
- standard electric hospital bed
- casts, canes, and crutches
- walkers and knee-walkers
- diabetic supplies including needles, syringes, lancets, and self-monitoring blood glucose test strips

- oxygen: you must always submit a Prior Authorization form, signed by a medical professional
- standard artificial limb. If you select a myo-electric or sport prosthesis, we limit your payment to the price of a standard prosthesis.
- artificial eye, splint, truss, cast, cervical collar, brace, excluding dental braces
- ostomy supplies, when a surgical stoma exists
- wigs for oncology related diagnosis and external breast prosthesis following a mastectomy
- sterile surgical bandages, dressings or burn jackets used for post-surgery treatment or treatment of open wounds

We reserve the right to require that you purchase equipment from a preferred supplier.

Exclusions: benefits aren't payable for the following medical equipment:

- portable oxygen concentrators and oxygen used outside the home, including oxygen concentrators and oxygen used while travelling by air, land, sea, rail, or other means
- purchase of, or subsidy of power scooter, paediatric power based and adult power-based wheelchair, heavy duty model wheelchair, paediatric specific specialty stroller, paediatric manual and lightweight dynamic tilt wheelchair, or lightweight manual standard wheelchair
- wheelchair components and repairs including: upholstery, swing away detachable footrest parts, foot/leg support, back hardware, back support, armrests, brakes and replacement parts for brakes, brake extensions, front casters, wheels, lateral support hardware and custom fabricated lateral support options, pommel hardware, pommel/adductors, positioning belts, seat cushion, seat cushion hardware, replacement seat, tray and replacement tray, joy stick and joy stick replacement, power tilt and recline, control box, or power add-on device
- charges that are more than our guidelines, higher than what we consider to be usual, reasonable and customary or charges for devices not appearing on our list of approved devices
- charges for duplicate or replacement prosthetic appliances, devices, or medical equipment and supplies that are outside our guidelines for replacement
- blood glucose meters
- flash glucose devices and sensors
- continuous glucose monitoring devices, sensors and transmitters
- continuous subcutaneous insulin infusion devices (insulin pumps) and supplies

Mental health and therapy

Charges for direct counselling services by a registered psychologist, clinical counsellor, registered psychotherapist, registered marriage and family therapist, speech therapist, registered social worker for stress management, emotional problems, learning and behavioral problems, and alcohol and drug abuse.

Orthotics – custom-made

Charges for the purchase of custom-made orthotics, plaster cast or computer topography. You must send us a Prior Authorization form, signed by a physician, nurse practitioner, chiropodist or podiatrist.

Paramedical services

Covers charges up to the amount between what your government health insurance plan covers and what is reasonable and customary for the services of these licensed and registered practitioners: acupuncturist, chiropractor, osteopath, naturopath, chiropodist, podiatrist, physiotherapy, massage therapist, and dietitian. We may require a referral completed by a physician or nurse practitioner for the initial visit. Benefits are payable only after the yearly maximum allowed under the government health insurance plan has been reached, if applicable.

Exclusions:

- services provided by a family member
- services provided by an individual who does not have an agreement with a government health insurance plan

Fracture benefit (only available on HealthStarter plan)

If an insured person, because of an accident, sustain a fracture listed in the accompanying *Schedule of Benefits*, we'll pay the amount specified. Where more than one fracture is sustained as the result of any one accident, only the largest amount is eligible.

Dental benefit (not available on DrugPlus or HealthStarter plans)

Refer to your *Schedule of Benefits* for coverage amounts under your plan.

We'll reimburse you for dental care or services, provided the charges don't exceed the amount stated in the *Provincial Dental Association Suggested Fee Guide for General Practitioners* in effect at the time the services are done. Before the maximum amount is paid, you must process the co-payment first. Benefits aren't payable for dental care or services done outside your home province or territory or for charges that happen before the policy start date.

Alternate benefit provision: We reserve the right to consider alternative procedures, services, courses of treatment and materials, and to provide benefits based on the least costly treatment which would produce a professionally adequate result, consistent with accepted standards of dental practice. The fact that a similar procedure, service, course of treatment or material may have been previously used has no bearing on this provision.

Ongoing maintenance services

- examinations
- diagnostic services
- preventive services
- pit and fissure sealant - on permanent molars only (up to and including age 15)
- restorations, including bonded amalgams at non-bonded rates
- scaling
- root planing
- select extractions
- polishing

Oral surgery, endodontic services, periodontal services and other services
Not available with Basic or Starter Plans

- adjunctive services
- space maintainers
- denture repair, reline, rebase, adjustments
- anaesthesia

Major restorative – Not available with Basic or Starter Plans

- dentures, including premium dentures, reimbursed at non-premium fees
- crowns, including bonded crowns reimbursed at non-bonded fees
- bridges
- orthodontic

If you need major restorative services, you must send us x-rays and a treatment plan completed by your dentist before any work or treatment begins. We'll contact you to tell you the amount of treatment eligible under your plan.

Fees for in-office or commercial laboratory services or study models for a covered service are included.

Accidental death and dismemberment benefit

This benefit pays for a loss directly resulting from accidental bodily injury or accidental loss of life. Coverage is provided on a 24-hour basis and the loss must occur within 365 days from the date of the accident. Payment for accidental loss of life of the insured will be made to the insured's estate, unless the insured previously specified otherwise in writing. Payment for all other losses will be made to the insured.

If an insured suffers more than one loss as a result of an accident, payment shall be limited to the greater of the amounts stated for any single loss due to any one accident.

Benefits are not payable for a loss that was a result, directly or indirectly, or was in any manner or degree associated with, or occasioned by, any one of the following:

- self-inflicted injury,
- suicide or attempted suicide,
- sickness or disease,
- terrorism, war, (whether or not war was declared) or participation in any civil disorder or riot,
- committing or attempting to commit a criminal offence,
- operating a vehicle while impaired by drugs, toxic substances or an alcohol level in excess of the applicable legal limit. Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes, but is not restricted to, an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat,
- a flight accident, unless riding as a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of 6 people or more, or
- participation in professional sports; participation in any speed contest using a motorized vehicle (where "vehicle" means any form of transportation which is drawn, propelled or driven by any means and includes, but is not restricted to, an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat); parachuting; hand gliding; bungee jumping; mountaineering; cave exploring; SCUBA diving (unless you hold a basic SCUBA designation from a certified school or other licensing body).

Vision benefit

When prescribed by a registered, certified or licensed ophthalmologist or optometrist and dispensed by a licensed ophthalmologist, optometrist or optician, we'll consider charges up to the maximum payable specified in your *Schedule of Benefits* for:

- prescription eyeglasses, including lenses and frames
- contact lenses
- laser eye surgery
- optometrist visit, in provinces where optometrist visits aren't covered by a government health insurance plan.

We won't pay benefits for:

- safety glasses or non-prescription sunglasses
- services or supplies which are not for your own personal use
- eyewear cleaning supplies and accessories

Survivor benefit

This benefit provides that, for a period of 1 year following the death of an adult insured, coverage for a remaining adult insured or eligible dependent will be maintained and the payment of premiums waived. The waiver of premium doesn't apply to the Vitality charge.

If it is the primary insured who has died, participation in the Manulife *Vitality* program ends immediately. When the survivor benefit period ends, only the new primary insured may apply for a new policy that includes the Manulife *Vitality* program.

If a spouse or co-insured dies, the primary insured's membership in the Manulife *Vitality* program remains the same.

Prescription drug benefit

Not available on DentalPlus or HealthStarter plans.
Refer to your *Schedule of Benefits* for specific coverage amounts

We'll only reimburse charges for generic drugs and medicines that are listed in the applicable Manulife formulary (the Formulary) at the time the claim is submitted.

Exception: Quebec residents, are reimbursed for generic drugs and medicines listed in either the Formulary or the *Régie de l'assurance maladie du Québec* (RAMQ) list, but only for charges not already paid under the RAMQ plan.

We compile and manage the Formulary to include all eligible drugs, available strengths, dosage forms and drug identification numbers (DINs). Using pharmoeconomic studies as a guide, the Formulary is dynamic and subject to change. When an equally safe, effective and less costly drug is available, we update the Formulary to add and remove approved drugs.

We may ask you to try alternative, less expensive drug therapies before considering a more expensive one.

We determine the amount payable based on the lower of the actual cost or the lowest cost generic equivalent. Drugs and medications must be prescribed by a physician, nurse practitioner or dentist and dispensed by a licensed pharmacist. Some drugs require prior authorization.

Exclusions:

- preventive vaccines and medicines (oral and injected)
- anti-obesity drugs, food supplements, and general public products, whether or not prescribed
- dietary supplements, vitamins and infant foods including natural health products, nutritional products, iron products, potassium supplements, anti-aging products, cosmetic and hair growth products
- over-the-counter drugs
- vitamins (other than injected vitamins), vitamin or mineral preparations, homeopathic products, probiotics
- the cost of giving injections, serums, and vaccines
- injected vitamins for weight loss purposes and chelation therapy
- pandemic screening tests,
- pre-exposure prophylaxis
- drugs paid for by any government plan
- drugs not approved for legal sale to the general public in Canada
- any drugs that are administered in a hospital
- erectile dysfunction drugs
- smoking cessation aids
- that part of any one prescription for drugs or medicines which is:
    - more than a three-month supply, unless prior approval has been given by us, or
    - covers a period for which we haven't received premium payments
- assisted conception,
- birth control (if excluded in the *Schedule of Benefits*)
- any exclusions outlined in the counteroffer, if applicable

Catastrophic coverage benefit

Not available to residents of the province of Quebec.

This benefit provides the following coverage, subject to the terms of this policy.

Prescription drug coverage

This benefit provides 100% coverage for prescription drugs after a threshold of prescription drug costs specified in the *Schedule of Benefits* in an anniversary year has been reached only out of pocket prescription drug expenses incurred by an insured person under any insurance plan providing coverage for prescription drugs may be used to calculate the threshold amount required to be reached before this benefit will be is available. Out of pocket expenses mean expenses incurred and paid by or on behalf of an insured person which are not covered and/or reimbursed under such a plan.

After reaching this threshold, 100% of prescription drug coverage will be available until the following year, at which time the threshold begins anew (see the *Schedule of Benefits* for the annual period applicable in your province of residence).

Catastrophic health plans will provide coverage for drugs and medicines as defined herein and listed on Manulife's Formulary. The amount payable for all drugs and medicines under this benefit after the threshold has been met will be at 100% of the cost, provided that payment of benefits shall be co-ordinated with payments available under any other health insurance plan, prepaid plan or government health insurance plan, to the extent that the total payments under all policies or plans shall not exceed 100% of eligible charges incurred. Proof of prescription drug expenses is required when a claim is made under this benefit.

Homecare, private nursing, medical equipment and prosthetic appliance coverage

This benefit provides 100% coverage for homecare, private nursing, medical equipment and prosthetic appliance expenses, up to a maximum of $25,000 per anniversary year, after you reach an annual threshold of $7,500 of expenses for these benefits in an anniversary year has been reached. Proof of expenses for homecare, private nursing, medical equipment and prosthetic appliances totaling $7,500 is required when the claim is made. Coverage for homecare, private nursing, medical equipment and prosthetic appliance expenses will be available until the next policy anniversary date, at which time the $7,500 claim deductible threshold will begin anew. There is a lifetime maximum of $100,000 for homecare, private nursing, medical equipment and prosthetic appliance benefits.

Physiotherapist and chiropractor

This benefit provides 100% coverage for physiotherapy and chiropractic expenses after the happening of an accident requiring a minimum hospital stay of 24 hours. Coverage is available for 1 benefit year from the date of such accident.

Preferred hospital accommodation benefit

Refer to your *Schedule of Benefits* to confirm if this coverage is included in your plan and for the maximum amount of coverage. If you're hospitalized in your home province or territory because of sickness or bodily injury, we'll pay for daily room charges more than the standard ward rate made by a hospital for semi-private room or private room accommodation.

If you're less than 21 weeks pregnant on the application date, we'll cover a maximum of 2 days of hospitalization if hospitalization is a result of the pregnancy or complication of the pregnancy. Coverage for pregnancy or complications of pregnancy aren't recognized if you're 21 weeks pregnant, or greater, on the application date.

This benefit doesn't include accommodation in a private hospital, a chronic care hospital, chronic care unit of a hospital, or a transition ward of a hospital.

Hospital cash benefit

Refer to your *Schedule of Benefits* to confirm if this coverage is included in your plan and for the maximum amount of coverage. If you're hospitalized because of a sickness or bodily injury and if you've only obtained standard ward accommodation, the we'll pay the amount shown in your *Schedule of Benefits*. There is no benefit paid when you're confined in a chronic care unit of a hospital or private hospital.

Exclusions to health care benefits

In addition to any other exclusions set out in this policy, benefits are not payable for:

- expenses payable under any government health insurance plan or available manufacturer rebate program,
- care, services or supplies for cosmetic purposes, except when in connection with reconstructive surgery to repair or replace tissue damaged by disease or bodily injury,
- drugs, tests, services, treatment or supplies not medically necessary, or we consider experimental,
- pandemic screening tests,
- expenses more than those in our guidelines, those we consider to be usual, reasonable and customary, or for devices not appearing on our list of approved devices,
- hospitalization if you're confined in a hospital on the start date, except when the confinement is due to an emergency occurring after the application date,
- services, equipment and supplies provided by or on behalf of a chronic care or psychiatric hospital or institution, chronic care unit of a hospital, psychiatric unit of a hospital or when a patient is confined to a long-term care facility or a transition ward of an acute hospital,
- expenses related to a sickness, injury or other loss suffered where payment under this policy is not permissible by law,
- duplicate or replacement prosthetic appliances, devices, or medical equipment and supplies that are outside our guidelines for replacement,
- expenses from an act or accident of war, declared or undeclared, or due to any type of military conflict or act of terrorism,
- any or all charges no longer payable under any government program after the policy start date,
- drugs, medicines, services or supplies self-prescribed, or prescribed by or for family members,
- expenses related to a sickness, injury or other loss suffered in relation to medical conditions or ailments as specified in the counter-offer letter signed and accepted by the policy owner, where applicable,
- services or supplies payable or available, regardless of any waiting list, under any government-sponsored plan or program unless explicitly covered under this benefit,
- prescription drugs, services or supplies that are not approved by Health Canada or any other government regulatory body,
- charges, services, supplies or treatment that aren't generally recognized by the medical profession in Canada as appropriate, effective, or required for the treatment of an accident, injury or illness in accordance with Canadian medical standards, or
- services, supplies, devices or items that don't qualify as medical expenses under the *Income Tax Act (*Canada), unless covered under this policy.

4 Emergency medical travel benefits

This benefit is automatically included in your plan and is only available to those under age 70. Refer to your *Schedule of Benefits* for details of your coverage.

Availability of benefits

Refer to your *Schedule of Benefits* for specific coverage amounts.

The emergency medical travel benefit is available to residents of Canada to cover eligible expenses over and above those paid by their government health insurance plan. Benefits are available for medically necessary care, services or supplies required because of an emergency illness or injuries that happen outside your home province or territory. Benefits are provided to an overall maximum of $5 million, per insured person, for each incident.

Please note the following:

- A deductible of $100 is applied to each unrelated incident or claim.
- You must meet the eligibility requirements of this policy and have emergency medical coverage that's valid for the entire duration of the trip. If the coverage doesn't cover the entire duration of a trip, an extension of coverage is available, but must be purchased before you depart on your trip.
- Only expenses due to an emergency that happen outside your home province or territory during the period covered as described in your *Schedule of Benefits* are eligible. For example, if the period covered is a maximum of 9 days, the medical emergency must take place during the first 9 days of your travel. The 9-day period starts when you cross the border of your province or territory of residence. If travelling by air, at the time the airplane takes off.
- The emergency medical coverage ends on the earliest of:
  - the date you return to your province or territory of residence,
  - the date you reach your maximum number of days for each trip, or
  - when coverage expires on your 70th birthday.
- Your coverage includes an unlimited number of trips taken outside your province or territory of residence during the year under these conditions:
  - Each trip is limited to the number of days specified in your plan unless additional extended coverage insurance is purchased.
  - A trip ends when you return to your province or territory of residence, or the coverage period limit has been reached. This includes additional coverage purchased with a travel extension policy.
  - You must remain in your province or territory of residence for a minimum of 24 hours before another trip qualifies for coverage.
- You may be able to extend your coverage if your trip:
  - is longer than the maximum number of coverage days you have under your current plan, or
  - will extend beyond the expiry date shown on your confirmation.
- To extend your coverage, you must either:
  - purchase extended coverage before the expiry date of your Multi-Trip plan for any additional travel days, or
  - purchase a new Multi-Trip Emergency Medical plan, with no lapse in coverage, providing the total duration of the trip doesn't exceed the maximum trip length you choose.

  If your Multi-Trip plan isn't underwritten by Manulife, it's your responsibility to confirm that an extension of coverage is permitted on your current plan with no loss of coverage. When you apply for an extension of coverage, you may be required to answer questions about your health.
- For the purposes of this benefit, days are determined on a calendar-day basis. The day of departure, the day of arrival and every calendar day in between, are each counted as a day.

Failure to contact the Assistance Centre within the first 24 hours of hospitalization limits your benefit to 70% of eligible expenses to a maximum of $25,000. We'll waive this condition if you or your travelling companion are unable to phone within the first 24 hours of the incident because of an incapacitating or acute illness or injury.

Description – Emergency medical travel benefits

Subject to any other provision contained in this policy, this plan provides up to $5 million in total benefits per insured person, for each incident, for usual, reasonable, and customary charges that took place, during the travel period of coverage, for these benefits.

Accidental dental

Treatment to natural teeth due to an external accidental blow to the mouth or head, up to a maximum of $2,000. You must see a physician, nurse practitioner, or dentist immediately following the accident and obtain an accident report from the medical professional for claim purposes. Benefit maximum includes all related costs associated with treatment.

Air transportation

In the event of a medical emergency, the cost of returning you to Canada for immediate medical treatment. All air transportation arrangements must be pre-approved by us and arranged by The Assistance Centre.

- benefit includes the extra cost for the purchase of the most economical airfare, plus the additional most economical airfare, if required, to accommodate a stretcher, to return you to a hospital or nearest appropriate medical facility in Canada.
- when we or the commercial airline require you to be accompanied by a qualified medical attendant, who isn't an immediate family member, we'll cover the usual, reasonable and customary charges of a medical attendant registered in the jurisdiction in which treatment is provided, including the most economical airfare, and overnight hotel and meal expenses, if required.

This benefit assumes that you're not holding a valid open-return air ticket. If you use the air ambulance or air transportation benefit, the unused portion of your air ticket must be given to us. The benefit also applies to one member of the family who is also covered by a Manulife travel plan and is travelling with the patient at the time of illness or injury.

Ambulance – air

The cost of air ambulance to the nearest appropriate medical facility or to a Canadian hospital when approved by us. All air transportation arrangements must be pre-approved and arranged in advance by The Assistance Centre.

Ambulance – ground

Licensed ground ambulance charges for service from the place of illness or accident to the nearest qualified medical facility capable of providing appropriate treatment.

Diagnostic services

Charges for laboratory tests and x-rays prescribed by the attending physician or nurse practitioner.

Doctor bills

Charges made by a physician or nurse practitioner, that are more than the amount paid by your government health insurance plan.

Friend or family hospital visits

The most economical round-trip airfare, by the most direct route from Canada, is reimbursed for one family member or friend, only if arrangements are pre-approved and made through The Assistance Centre.

We require written verification from the attending physician or nurse practitioner that the situation was serious enough to have required the visit to:

- visit you while confined in hospital. This benefit requires you to have been an inpatient for at least 7 consecutive days outside your province or territory of residence.
- identify the deceased insured person prior to the release of the body, where necessary.
- attend to your dependent children if they're left alone in your destination because of your illness or injury.

Hospital accommodation

Charges for a standard or semi-private hospital room accommodation, not a private room or suite, or for outpatient services provided by an active treatment hospital in an emergency while travelling outside your province or territory of residence. These charges must be more than the amount paid by your government health insurance plan.

Hospital expenses

Payment of up to $100 per emergency hospital stay while travelling, to cover incidental expenses. You must provide paid original receipts with your claim.

Meals and accommodation

We'll pay up to $150 per day, to a maximum of $1,500 per policy, for your commercial accommodation and meals when return to your province or territory of residence is delayed beyond your scheduled return date due to illness or injury to yourself or a travelling companion. An attending physician or nurse practitioner must provide a written statement that you or your travelling companion are unable to travel due to the illness or injury. Claims must be supported with detailed original receipts from commercial organizations and medical reports.

Medical appliances

The cost of splints, casts, crutches, canes, slings, trusses, walkers, or the temporary rental of a wheelchair when prescribed by an attending physician or nurse practitioner, obtained outside your province or territory of residence, and required due to an accident or unexpected illness.

Paramedical services

Charges up to $300 for services provided by a licensed or registered: physiotherapist, chiropractor, chiropodist, podiatrist or osteopath, including x-rays, when required for emergency treatment.

Prescription drugs

Drugs, serums and injectables prescribed by a physician, nurse practitioner or dentist and supplied by a licensed pharmacist, physician, nurse practitioner or hospital. This doesn't include vitamins, patent or proprietary products, when required for emergency treatment. You must submit original, paid receipts for claim purposes.

Private registered nurse

Coverage to a maximum of $3,000 for charges of a licensed, private registered nurse, who isn't an immediate family member, who performs registered nursing duties, during and immediately following hospitalization, when ordered by the attending physician or nurse practitioner.

Relief of dental pain

Treatment for the emergency relief of dental pain, other than accidental dental, is covered to a maximum of $200. Treatment must be performed at a location at least 200 km from your province or territory of residence.

Return of deceased

A maximum of $3,000 towards the cost of preparation and transportation to the province or territory of residence of a deceased insured person, excluding the cost of a coffin, or up to $2,500 towards the cost of cremation or burial at the place of death, outside the province or territory of residence of the deceased insured person.

Treatments - blood

The cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes are covered, when provided due to emergency hospitalization.

Vehicle services

We'll pay up to $2,000 towards the cost of driving your vehicle, including boat or RV, either private or rental, to your province or territory of residence or the nearest appropriate vehicle rental agency, when you or your travelling companion are unable to, due to an unexpected illness or injury. You must provide written medical certification and paid original receipts for your additional expenses, such as fuel, accommodation, meals, airfares, etc. If your private vehicle is stolen or inoperable due to an accident, costs are covered for the most economical airfare, to return you by the most direct route to your province or territory of residence. We require the original official police report of the theft or accident.

Automatic extension of coverage

Coverage for any trip expires at 11:59 PM, local time on the last day of the coverage period or trip maximum for travel benefits. Coverage for any trip is automatically extended, without further charge to you, for up to 72 hours following:

- the hospital discharge date, when return to your province or territory of residence is delayed due to the hospitalization of you or your travelling companion and coverage for the trip expires after you're hospitalized,
- the expiry of coverage for the trip, when return to your province or territory of residence is delayed, by order of the attending physician or nurse practitioner, due to a covered illness or accidental injury,
- the expiry of coverage for the trip, when return to your province or territory of residence is delayed due to the delay of a common carrier such as an airplane, bus, taxi, train, on which you are a passenger, or the delay is caused by a traffic accident, or mechanical failure of a private automobile on way to the departure point. You must provide documented proof of the incident which caused the delay with your claim,
- the expiry of coverage for the trip, when return to your province or territory of residence is delayed due to extreme weather conditions, causing hazardous driving conditions. You must provide documented proof of the delay from the local authorities and weather office at the location with your claim.

The Assistance Centre

Help is as near as the phone. If you require assistance while you're outside your home province or territory, contact numbers are located on the back of your benefit card. The Assistance Centre may offer help in the following areas.

Assistance related to medical services:

- help locate a physician, nurse practitioner, clinic or hospital,
- confirm coverage to the hospital, physician, or nurse practitioner for eligible expenses,
- arrange payment to the hospital, physician, or nurse practitioner, wherever possible for eligible expenses,
- monitor medical treatment and keep the family informed,
- arrange transportation of a family member to the insured's bedside or to identify the deceased insured,
- arrange for transportation home of the insured, if medically permissible.

General assistance:

- provide emergency response in most major languages,
- assist in contacting family, business partner, employer, family physician or nurse practitioner,
- arrange for local care of dependent children and co-ordinate their return home, if the insured is hospitalized,
- arrange the transmission of urgent messages to family members or business partners,
- assist in the event of loss of passport(s) or airline ticket(s),
- help to access legal counsel in the event of a serious accident,
- co-ordinate embassy and consulate services.

You must provide a government health insurance plan card number to the Assistance Centre before payments can be arranged. Be sure to travel with the government health insurance plan card number for each member of the family.

Exclusions – Emergency medical travel benefits

In addition to any other exclusions set out in this policy, we won't pay any benefit or accept any liability for any claims relating, directly or indirectly, for:

- a medical condition that isn't stable within the consecutive 9-month period immediately before the date of departure from your province or territory of residence. This means any condition, injury, illness, disease, or related complication in relation to which:
  - you have new symptoms, or existing symptoms have become more frequent or more severe or there has been a test result showing deterioration,
  - a physician or nurse practitioner, or other medical professional, has prescribed or recommended the medication dosage or frequency be reduced, increased, stopped or new medications have been prescribed for that condition,
  - a physician or nurse practitioner, or other medical professional, has prescribed or recommended a change in treatment for that condition, or
  - there has been an admission to a hospital or you're awaiting results for further investigation for that condition during the 9-month period.

  This exclusion doesn't apply to minor ailments or a change in medication where the active ingredient and strength remains the same, such as generic drugs.
- elective and non-emergency treatment, service or surgery. This includes, but isn't limited to, treatment, service, or surgery:
  - not required for the immediate relief of acute pain and suffering, or
  - which medically could be delayed until you return to Canada, or
  - which you elect to have done outside Canada following emergency treatment or diagnosis of a medical condition which, on medical evidence, wouldn't prevent you from returning to Canada prior to such treatment or surgery.
- hospital accommodation at other than an active treatment hospital
- experimental or investigative treatment or drugs
- emergency air transportation not pre-approved in advance by The Assistance Centre
- a medical condition for which, prior to departure, medical evidence would suggest a reasonable expectation that treatment or hospitalization could be required while on the trip
- emergency medical care benefits exceeding $5 million per insured person
- expenses from outside your province or territory of residence, when you could have returned to your province or territory of residence without endangering your life or health
- any insured person travelling outside their province or territory of residence primarily with intent or incidentally, to seek medical advice or treatment, even if the trip is on the recommendation of a physician or nurse practitioner
- any hospitalization or services done for general health examinations or check-up purposes, ongoing maintenance of an existing condition, regular care of a chronic condition, rehabilitation or ongoing care in connection with drugs, alcohol or any other substance abuse, or for cosmetic purposes
- travel booked or started contrary to medical advice or after receipt of a terminal prognosis
- hospital and medical care for full-term childbirth or childbirth that occurs after the 26th week of pregnancy, medical complications after the 26th week of pregnancy, deliberate termination of pregnancy. This exclusion applies to both you and the newborn
- any treatment required for a mental or nervous disorder
- services provided by naturopaths, optometrists or for cataract surgery
- treatment for abuse of medication, toxic substances, alcohol or the use of non-prescribed drugs
- self-inflicted injury of or to a person covered under this policy unless medical evidence establishes that the injuries are related to a mental health illness
- the commission or attempted commission of a criminal act under the legislation of the jurisdiction where the act was committed

- participation in professional sports, speed contests in a motorized vehicle, extreme sports, SCUBA diving, unless you hold a basic SCUBA designation from a certified school or licensing body, or a flight accident, unless you're a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of 6 people or more
- a declared or undeclared act or accident of war, or due to any type of military conflict including acts of terrorism
- any medical condition you suffer or contract when an official travel advisory issued by the Canadian government before your departure date states, "Avoid all non-essential travel" or "Avoid all travel" regarding the country, region or city of your destination. To view the travel advisories, visit the Government of Canada Travel site.

Conditions – Emergency medical travel benefits

Emergency travel medical care benefits are only available to residents covered by a government health insurance plan for the entire duration of the trip and who are travelling outside their province or territory of residence.

We only cover usual, reasonable and customary charges that take place as a result of a medical emergency. You're required to submit detailed accounts covering the hospital and medical services provided and reasonable proof of these expenses. If you don't, your claim may be denied.

If the air ambulance or air transportation benefit is used, the unused portion of your air ticket must be given to us.

In consultation with the attending physician or nurse practitioner, we reserve the right to transfer you to another hospital or return you to Canada. If you refuse to transfer, we're released from any further obligation or liability.

You must act at all times to minimize the costs to us.

When does coverage begin and end?

Coverage starts at the time of crossing the border of your province or territory of residence. If travelling by air, coverage begins at the time the airplane takes off. Coverage expires at the border of your province or territory of residence, or when the airplane lands in your province or territory of residence, on the return home or on the expiry date of this policy, whichever comes first.

Only charges for emergency medical services that take place while you're outside your province or territory of residence, during the term of this policy, are eligible.

Once a medical emergency ends, no further benefits are payable for any continuing treatment, recurrence or complications arising directly or indirectly from the condition which caused the medical emergency.

No benefits are payable for expenses that take place after the expiry date of this policy, unless during the period of coverage, you're admitted to hospital and not discharged prior to the expiry date of the period of coverage.

When is pre-approval required?

Pre-approval by the Assistance Centre for all interventions or procedures, including all diagnostic imaging, like Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) interventions is required. The exception is when these procedures are performed in extreme circumstances on an emergency basis supporting diagnostic aids for life or limb saving measures. Procedures routinely carried out within the emergency department such as minor lacerations repairs, drainage of abscesses, removal of foreign bodies and other minor emergency surgical procedures, chest x-rays, flat plates of bones and abdominal views, are also exempt from pre-approval.

How to make a travel claim

For travel claims inquiries, call 1-800-805-1008. When the Assistance Centre is contacted at the time of a medical emergency, complete directions for the submission of a claim will be provided.

If you're claiming benefits under this policy, but did NOT contact The Assistance Centre at the time the medical services were provided, or are seeking reimbursement of incidental expenses, you must:

- call 1-800-805-1008 to request a Claim Authorization and Release Form,
- submit the completed form with the original detailed invoices or original receipts from the service provider and written evidence of any amounts paid by a government health insurance plan and any other insurer or health plan,

- obtain a statement from the attending physician, nurse practitioner or hospital stating the diagnosis and treatment provided,
- provide translation for claims submitted in languages other than English or French.
- provide an identification number, and individual government health insurance plan card number with version code, if applicable, and the patient's date of birth.
- all claims must be submitted within 6 months from the date the incident happened.
- all pertinent documents must be sent to:
  Manulife Travel Insurance
  c/o Active Care Management
  P.O. Box 1237 Station A
  Windsor, ON N9A 6P8
- a claim form will be sent to the insured upon receipt of the above information.

Please note that ALL information must be completed on the claim form. Any missing information may delay the processing of a claim.

5 The Manulife *Vitality* program

The primary insured's Vitality Status under the Manulife *Vitality* program determines the premium savings to be enjoyed by the insured during each policy anniversary year. Premium savings are subject to change without notice.

Vitality Status

There are four Vitality Status levels: Platinum, Gold, Silver, and Bronze. Each status has a corresponding premium savings, shown in the attached Manulife *Vitality* program summary. The program summary also outlines the premium savings for the first year in the program. The first-year premium savings apply no matter what the primary insured's Vitality Status is on any other Manulife *Vitality* policy.

After the first year, the Vitality Status of the primary insured on each policy anniversary determines the premium savings for the next year (the 12 months following the policy anniversary). It's understood that the primary insured person's Vitality Status is determined 2 months before the start of the anniversary year.

If the primary insured is covered under more than one policy with the Manulife *Vitality* program (for example, a life insurance policy and a health and dental policy), the insured's Vitality Status is determined according to the policy with the earliest policy effective date.

Status qualification

The primary insured must meet certain Status qualification requirements to attain or maintain a Status other than Bronze. The Status qualification requirements are the criteria used to determine the insured's Vitality Status.

The insurer may administer the Vitality Status qualification requirements directly or may designate a third-party provider to do so. The insurer may designate or replace a third-party provider at any time without notifying an insured.

The insurer may change the Vitality Status qualification requirements from time to time without notifying the insured. A change to these requirements could affect the insured's ability to maintain a Vitality Status or attain an improved Vitality Status. The insured can get up-to-date information about the Vitality Status qualification requirements by visiting the website or by contacting the phone number shown on the Manulife *Vitality* program summary and other communications about this program.

The insurer, or the third-party provider may make offers to the insured, including access to information, discounts, tools, or other services designed to encourage the insured to participate in activities to help meet Vitality Status qualification requirements. These offers may change without notice from time to time and may vary based on the coverage or type of plan held by the insured.

Participation in the Manulife *Vitality* program ends at the earliest of the following dates:

- when the insured asks the insurer to cancel participation in the program,
- when the primary insured dies,
- if this policy lapses for non-payment of premiums, or
- when the policy ends for any other reason.

When participation in the Manulife *Vitality* program ends, the insured loses the Vitality Status he or she has attained and the rewards that have been earned.

The insurer does not reimburse any costs incurred to meet a Vitality Status qualification requirement.

6 More information about this policy

Applications

If we change or replace this policy, its rates, or any provisions, all applications made after that date are considered as applications for the revised policy and coverage. We issue policies according to the updated rates and provisions. Manulife, or a distribution outlet approved by us, validates all applications.

Beneficiary designation

There is no right to name a beneficiary under this policy.

Benefits

We reserve the right to change benefits under this policy for any reason. If we decrease benefits, we'll give you 30 days' notice. All benefit levels in this policy are applied on a per insured basis. Your coverage level is dependent on whether you purchased single or family coverage, unless otherwise stated.

Conversion privilege

When coverage ends for an insured due to divorce or for a dependent upon attainment of age 21, marriage, becoming an orphan, or obtaining employment, they may continue their own coverage under a separate policy. To maintain conversion privileges, the insured must contact us within 30 days of their coverage ending. Any adult insured or dependent wishing to exercise their conversion right may also join the Manulife *Vitality* program when they apply for conversion, but not after.

Co-ordination of benefits

We follow the co-ordinating coverage guidelines for out of country and out of province or territory expenses set out by the *Canadian Life and Health Insurance Association* (CLHIA).

This plan is a supplemental benefit plan and covers expenses that aren't paid under another benefit or insurance plan. You must send your claims for reimbursement to any government plans first. If you're eligible for similar benefits under another individual or group policy, such as credit card coverage, auto insurance, private insurance, workers' compensation, etc., you may co-ordinate benefits between this policy and those plans. Payment will never be more than the eligible expenses you paid.

If your other plan doesn't allow co-ordination of benefits, submit your claim to that plan first.

If your other plan does allow co-ordination of benefits, we prorate expenses among the plans, proportionate to the amounts that would have been paid if there was only one plan.

Limitation period

Every action or proceeding against us for the recovery of insurance money payable under the contract is absolutely barred unless started within the time set out in the *Insurance Act*, or other applicable legislation, or the *Limitations Act 2002*, for Ontario.

Limit of liability

We pay benefits according to the terms and conditions of this policy. We aren't responsible for:

- the availability, quality, or results of any medical treatment, care, supplies, or services a third party offers
- the lack of any medical treatments, care, supplies or services available due to pandemics, acts of terrorism, war and similar events
- the quality or results of transportation services a third party offers
- any acts or omissions in care, treatment, services, or supplies by a third party
- your failure to seek or obtain medical treatment

Misrepresentation and adjustments

If, within 2 years of the start date of the policy, any misrepresentation, concealment or failure to disclose correct information is discovered regarding any application made under this policy, we have the option to cancel the policy and limit our liability to the return of eligible premiums.

Where there are multiple people insured under the policy, we may either cancel the entire policy, modify or cancel only the coverage of the individuals insured to whom the failure to disclose relates. We'll maintain coverage for the remaining individuals insured under the policy, provided they aren't obligated to continue coverage in this manner.

In addition, we have the right to subtract any claims we've paid from any premiums we refund. After you've had your coverage for more than 2 years, we can't cancel any coverage unless you commit fraud.

Any intentional or non-intentional misrepresentation, concealment or failure to disclose correct information in claims submission gives us the option to cancel the policy or make you responsible for 100% of the amount of the claim, and for any costs we may pay during our claims investigation. This includes legal costs and any fees or costs paid to a private investigator. Both you and the policy owner, if different, are jointly and severally liable to pay us back in this regard, even after cancellation of this policy.

Multiple policies

You can't have:

- coverage under more than one Manulife individual health and dental plan, with or without the Manulife *Vitality* program at a time,
- coverage under successive Manulife health and dental plans that were issued within 24 months of the prior plan's cancellation

If we determine that you're covered under more than one policy at the same time, or under successor policies, we may give you notice and cancel one, more, or all the policies without refunding any premiums. We may recover any claims paid under any of the policies.

Non-transferable

This policy is not transferable to another person or family member.

Proof of age

We may request proof of age for any person insured under this policy. If a date of birth is misstated, the correct birthdate is used, and the following may occur:

- rates may be adjusted
- the date coverage starts may change
- the amount and type of coverage may be reduced or cancelled
- any rights or benefits provided under this policy may be changed

Provincial variations

We reserve the right to adjust the provisions described in this policy to meet the minimum requirements of law within your province or territory.

Release of information

By applying for this policy, you authorize us to release any information that's necessary for us to determine eligibility of benefits and to pay claims. Manulife and our service providers may ask for relevant information from physicians, nurse practitioners, dentists, hospitals, clinics, and service providers. Our privacy policy is available on manulife.ca.

Subrogation

When we pay you a benefit or assume liability under this policy, we reserve the right to recover money from the party at fault and, if necessary, to bring a legal action in your name. You agree to not interfere with this right and co-operate fully with us.

If you choose to exercise the right of recovery and sue directly, you agree to tell us and do everything necessary to protect our interests. If you recover any money, you must first repay us for any benefit payments we made to you under this policy for the claim, minus a reasonable amount for legal fees that you pay.

Waiving our rights

If we waive our rights in a specific instance, this doesn't prevent us from exercising our rights if the same or similar instance arises later.

7 Statutory conditions

These statutory conditions take precedence over all other provisions and conditions in this contract.

contract: The application, this policy, any document attached to this policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

copy of application: The insurer will, upon request, give to the policy owner or to a claimant under the contract a copy of the application.

material facts: No statement made by the policy owner or insured person at the time of application for this contract will be used in defense of a claim under or to void this contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

notice and proof of claim: The policy owner, an insured person, or a beneficiary entitled to make a claim, or the agent of any of them, must:

- give written notice of claim to us:
  - by delivery thereof, or by sending it by registered mail to the office of Affinity Markets, or
  - by delivery thereof to an authorized agent of the insurer in the province, not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability,
- within 90 days from the date a claim arises under the contract on account of an accident, sickness or disability, give to us such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the beneficiary if relevant, and
- if required by us, give a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract, and as to the duration of such disability.

failure to give notice or proof: Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate a claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the accident or the date a claim arises under the contract on account of sickness or disability, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

rights of examination: As a condition precedent to recovery of insurance moneys under this contract:

- the claimant shall afford to the insurer an opportunity to examine the person of the insured when and so often as it reasonably requires while the claim hereunder is pending, and
- in the case of death of the insured, the insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

termination by the insured: The insured may at any time request that this contract be terminated and the insurer will, as soon as practicable after the insured makes the request, refund the amount of premium actually paid by the insured that is in excess of the short rate premium calculated to the date of the request according to the table in use by the insurer at the time of the termination.

termination by the insurer: The insurer may terminate this contract at any time by giving written notice of termination to the insured and by refunding concurrently with the giving of notice the amount of premium paid in excess of the proportional premium for the expired time.

The notice of termination may be delivered to the insured, or it may be sent by registered mail to the latest address of the insured on the records of the insurer.

8 Terms used in this policy

Some of the terms used in this policy have a specific meaning and it's very important this policy is read and understood with these specific meanings in mind. Please familiarize yourself with these terms and their associated meaning whenever consulting this policy.

accident or accidental - an unintentional, sudden, unexpected, and unforeseeable event caused by an external event inflicting, bodily injuries.

active treatment hospital - an institution licensed as a hospital and operated for the care and treatment of resident inpatients with a Registered Nurse (R.N.) always on duty and with a laboratory and operating room (either on the premises or in facilities controlled by the hospital) where surgical operations are performed by a legally qualified surgeon. It doesn't include any hospital or institution or part of such hospital or institution licensed or used principally as a clinic, chronic care or extended care facility, convalescent home, rehabilitation centre, rest home, nursing home or home for the aged, health spa or treatment centre for drug or alcohol abuse.

act of terrorism - any activity that involves violence or the threat of violence, the commission or threat of a dangerous or menacing act, or the use of force, directed against the public, governments, organizations, buildings, infrastructure, or electronic systems. The intention of this activity is to: instill fear in the public, disrupt the economy, intimidate, coerce, or overthrow a sitting government or occupying power or, promote political, social, religious, or economic objectives.

act of war - hostile or warlike action, whether declared or not, in a time of peace or war, whether initiated by a local government, foreign government or foreign group, civil unrest, insurrection, rebellion, or civil war.

anniversary year - the 12-month period that follows the start date of the policy, and each 12-month period after.

application date - the date we receive the application at our office.

benefit year - each successive 12-month period following the date of the first claim for a specified benefit under the policy.

brace – a rigid or semi-rigid supporting device or appliance that fits on and attaches to any part of the body. This excludes braces used for dental defects, deficiencies, or injuries.

calendar year - the 12-month period that starts on January 1 and ends on December 31.

change in medication - medication dosage or frequency is reduced, increased, stopped or new medications are prescribed.

claim - eligible expenses for an illness or injury while this policy is active, or the act of telling us that you have expenses and you request payment.

claimant– the insured person who makes a claim under this policy.

clinical counsellor – a licensed professional who provides counselling services to help people understand and address personal development and mental health issues. Clinical counsellors must hold a counselling certification or degree recognized in the province or territory where they practice and registered with a federal or provincial association of counsellors.

consult or consulted - seeking advice or treatment from a physician or health care professional for any condition, injury, disease, or disorder. This includes discussions of potential future testing or surgery.

co-payment - the percentage of charges for eligible benefits that we pay.

dentist, **denturist** - a doctor of dentistry licensed in their region where they provide services or supplies. The treating dentist or denturist may not be you or one of your immediate family members.

dependent- a child listed on the application who you are responsible for by law. An insured child is under 21 years old, unmarried, doesn't work full-time, and relies on you for financial support.

DIN - Drug Identification Number (DIN) is a computer-generated 8-digit number assigned by Health Canada to a drug product prior to being marketed in Canada.

effective date – the date coverage under this policy begins. Also referred to as the start date.

eligible expenses - expenses covered by this plan, according to the provisions, terms, limitations, and exclusions of the policy.

emergency - an acute, unexpected or unforeseen illness or accidental injury which results in a sickness or accidental bodily injury of the insured person.

experimental - a service, drug, treatment, or medical device that isn't approved by The Health Protection Branch of Health Canada for use in Canada or that isn't considered appropriate or acceptable by the medical profession.

family coverage - your benefits cover a maximum of 2 adults aged 18 and older, and eligible children up to the age of 21 listed on the application form.

government health insurance plan - any plan or arrangement provided by or under the administrative supervision of any Canadian government agency (except the province of Quebec) which provides coverage or reimbursement for any health care service or supply, including but not limited to the health insurance plan of your province or territory of residence, homecare program, assistive devices program and the *Workers' Compensation Act* or similar legislation in your province or territory of residence. The Interim Federal Health Program (IFHP) is an exception and isn't considered a government health insurance plan.

health care professional - any licensed, regulated health professional whose occupational duties include the provision of treatment, advice, consultation, diagnosis or hospitalization. They may not be you, or your immediate family member.

hospital - a public hospital licensed under the *Public Hospitals Act* or similar legislation of the province or territory in question or recognized by the Ministry of Health of the province or territory in question as a public hospital, or a duly licensed general active treatment facility in another jurisdiction. Unless expressly stated otherwise in this policy, the term doesn't include a federal hospital, private hospital, rest home, nursing home, convalescent home, chronic care facility, health spa or hotel, a home for the aged, a rehabilitation centre or an institution used primarily for the confinement or treatment of alcoholism or drug addiction.

hospitalization - admission to a licensed facility where inpatients receive medical care and diagnostic and surgical services under the supervision of a staff of physicians or nurse practitioners, with 24-hour care by registered nurses.

immediate family member - the spouse, children, parents, and siblings of an insured person.

injury - sudden bodily harm caused by external and purely accidental means, independent of any sickness or disease, and requires immediate medical treatment.

inpatient - confined to a hospital for more than 24 consecutive hours.

insured or insured person - a maximum of 2 people, aged 18 years or older, covered under this policy and by a government health insurance plan, providing premiums continue to be paid. Also refer to the term dependent.

insurer - The Manufacturers Life Insurance Company (Manulife).

interchangeable drug - includes but is not limited to a:

- generic equivalent to the brand name drug considered to be interchangeable by law where the drug is dispensed.
- drug that contains the same active ingredient that isn't considered to be interchangeable in the province or territory where the drug is dispensed, but we identify as interchangeable.

licensed, certified or registered - licensed, certified, or registered by the proper authority or professional body in the region where treatment or services are offered.

loss - when a limb is completely severed at or above the wrist or ankle joint, or total and irrevocable loss of all sight.

medical profession - physicians, nurse practitioners, nurses, and other health care providers, and their governing bodies, associations, and interested groups. This includes, but isn't limited to: The Ministry of Health, The College of Physicians and Surgeons, or similar provincial or territorial bodies and medical associations.

medically necessary - care, services, or supplies you receive from a physician, nurse practitioner, or health care professional that we consider:

- appropriate and consistent with the symptoms, findings, diagnosis, and treatment of your illness or injury,
- generally accepted medical practice in Canada, and
- cost-effective.

The fact that your physician or nurse practitioner prescribes the service or supplies doesn't automatically mean that it's medically necessary and covered by the policy.

minor ailment - any condition that doesn't require:

- medication for more than 30 days,
- follow-up or referral visit to a medical practitioner,
- hospitalization, or
- surgical intervention.

nurse - a person licensed or registered by the nursing regulatory body, college or association in the province or territory where they work.

nurse practitioner (NP) - a qualified registered nurse who has completed a graduate degree in nursing and is licensed in their region to:

- provide direct care to patients in the diagnosis and management of disease and illness,
- prescribe medications,
- order and interpret laboratory tests,
- initiate referrals to specialists, and
- isn't the insured person, or an immediate family member.

pandemic – a contagious illness occurring worldwide, crossing international boundaries, and affecting a large number of people.

period of coverage – the number of days you have coverage, according to the plan option you chose.

pharmacoeconomics – the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife.

physician – a Doctor of Medicine (MD), legally qualified to practice medicine and perform surgery without restriction in the area where the services are provided. The treating physician may not be you or an immediate family member.

policy – this insurance policy, including your application for insurance, any documents we attach to it, and any future amendments.

policy owner – the person this policy was issued to and with whom we entered into an insurance contract.

policy anniversary – the anniversary of the month and day of the start date of the policy.

primary insured person – the person listed as the primary applicant on the application for insurance. This person is usually the policy owner and the person responsible for the premiums on the policy.

private hospital – a private hospital as defined in the *Private Hospitals Act of Ontario* and licensed by the Ministry of Health as such, or an equivalent hospital outside Ontario.

registered nurse (RN) – a person who:

- holds a certificate as a registered nurse (RN) under the *Health Disciplines Act* or similar legislation, or
- is registered or licensed in another area to provide services equivalent to those provided by an RN, and
- isn't a registered practical nurse (RPN), and
- isn't you or an immediate family member.

registered practical nurse (RPN) or licensed practical nurse (LPN) – a person licensed, certified, or registered in the area where the services are provided, and who isn't you or an immediate family member.

resident – a person who:

- has a valid provincial health insurance card,
- maintains a permanent residence in Canada, and
- has been in the country for at least 183 days during the past 12 months.

scans: an image or PDF of your application and any applicable medical Prior-Authorization form is as good as and as binding as the original. This doesn't apply to receipts as originals must be sent when requested.

single coverage – benefits cover only you and don't cover any family members

speed contest – a competitive activity where speed is a determining factor in the outcome of the event

spouse - a person who has coverage under a government health insurance plan, and is legally married to you or lived with you in a conjugal relationship for at least 12 months in a row

travelling companion - any person who has prepaid accommodation and, or transportation with you for the same covered trip.

treatment – any reasonable medical, therapeutic or diagnostic measure, prescribed by a dentist, physician, nurse practitioner, or health care professional in any form. This includes prescribed medication, reasonable investigative testing, hospitalization, surgery or other prescribed or recommended medical care directly referable to the condition, symptom or problem.

trip - any excursion taken by you outside your province or territory of residence while this policy is active.

usual, reasonable, and customary – in relation to charges:

- usual means typical charges for a service given or supplied by a provider
- reasonable means charges consistent with representative fees and prices which would normally be made in the absence of coverage under this policy
- customary means a range of usual charges by providers with similar expertise and services

vehicle - a passenger automobile, motorcycle, motor home, truck, R.V., and all Class A, B & C vehicles under 11 metres or 36 feet, providing the vehicle isn't licensed to carry passengers for hire.

Vitality charge means the amount charged by the insurer for the Manulife *Vitality* program. The Vitality charge is shown in the Manulife *Vitality* program summary included with this policy and the annual renewal notice.

Vitality Status means the primary insured's status level under the Manulife *Vitality* program, described in more detail in Section D under the heading The Manulife *Vitality* program.

Underwritten by The Manufacturers Life Insurance Company (Manulife)

Eligibility for Vitality rewards may change over time and are not guaranteed over the full life of the insurance policy.

Manufacturers Life Insurance Company provides the Manulife *Vitality* program. The Manulife *Vitality* program is available with select policies. Vitality and Vitality Status are trademarks of Vitality Group International, Inc., and are used by the Manufacturers Life Insurance Company and its affiliates under license. The Manulife trademark is also used by Vitality Group International, Inc. and its affiliates under license.

P.O. Box 670 Station Waterloo, Waterloo, Ontario N2J 4B8, 1-800-268-3763 manulife.ca

Accessible formats and communication supports are available upon request.
Visit manulife.ca/accessibility for more information.

Manulife