Manulife

The Manufacturers Life Insurance Company (Manulife)

CAA Health and Dental Plan

You've made a great choice to buy supplemental health care coverage and we're pleased that you've chosen Manulife through your CAA membership.

This document contains details about your policy and how to use it. Your contract includes this policy document, attachments, and any amendments. The effective date, also known as the start date, of this policy appears on the attached 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 plan 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 that removes or restricts your right to designate persons to whom or for whose benefit insurance money is to be payable.

Sincerely,

Roy Gori
President and Chief Executive Officer
The Manufacturers Life Insurance Company (Manulife)

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 to your bank account, minus any claims we've paid. If the claims we paid are more than your 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 commenced under a previously issued policy.

The Manufacturers Life Insurance Company (Manulife)
Individual Insurance, PO Box 670, Station Waterloo,
Waterloo, Ontario N2J 4B8
1 877-261-8222 – manulife.ca

Table of contents

Important: This policy contains exclusions, limitations, conditions, deductibles, maximums, and definitions. Please read it carefully. In the section called *Terms used in this policy,* you'll find explanations for the terms we use in this policy.

Coverage under this policy isn't available in the province of Quebec.

Before you begin

In this policy, “you” and “your” mean the owner of the policy, the primary insured, or anyone insured under this policy.

“We,” “our,” and “us” mean The Manufacturers Life Insurance Company (Manulife).

To be eligible for any claims, this policy must be in good standing, which means the policy premiums must be paid in full to the current date. You must be a resident of Canada, living outside the province of Quebec at all times and be registered for your provincial or government health insurance plan (GHIP) for the duration of this contract.

You’re only eligible for the benefits mentioned on your Schedule of Benefits. Not all plans include every benefit described in this contract. Please read your Schedule of Benefits to see what your benefits include. All benefits are subject to consideration of usual, reasonable, and customary charges typical for medically necessary conditions.

This policy is a legal contract between you and us.

We occasionally use the phrase “according to the terms and conditions of this policy.” We may change the terms and conditions without notice to reflect corporate policies, economic changes, revisions to usual, reasonable and customary charges 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.

We reserve the right to change premiums required for this policy based on its payment of benefits experience. We also reserve the right to alter the benefits to align with changes to the government health insurance plan (GHIP) or for any other reason, upon 30 days written notice to you.

When we say we’ll notify you, we mean that we will send it to your address as shown in our files. Please let us know if your address changes.

Coverage under this policy isn’t available in the province of Quebec.

Go to the website: manulife.ca/secureserve, to view the latest contract.

1 Benefit payments

Eligible expenses for care, services, supplies, sickness, injury, or other loss are paid for people who are insured on this policy. The benefits are paid according to the exclusions, limitations, and conditions in this policy and the Schedule of Benefits, and also according to any amendments to this policy.

We pay claims for eligible expenses:

- according to usual, reasonable and customary charges as determined by us and the maximums stated in the policy or the Schedule of Benefits.
- if the care, services, or supplies are medically necessary and prescribed by a physician, nurse practitioner, dentist, denturist, or other licensed health care professional.
- that aren't available through a government health insurance plan.
- that aren't prohibited by law for us to pay.
- if a claim is submitted with written proof that we ask for (such as receipts) within 12 months of the expense.

2 Description of benefits

The following health care benefits are available under this policy. Benefits are subject to limitations, exclusions, and coverage reductions that appear in the description of a benefit, under a separate heading, or in the Schedule of Benefits.

All benefits described in this policy may not be applicable to or covered under this plan. See your Schedule of Benefits for the details about your specific coverage.

Extended health care benefits

Payments for care, services, or supplies listed in this section are subject to the maximum amounts stated in the Schedule of Benefits for this policy.

Accidental dental

Dental treatment of natural teeth because of an accidental injury to the head or mouth, and not because an object was placed into the mouth, provided the injury is sustained after the effective date. Charges not reimbursed by us are your responsibility.

You must:

- notify us within 90 days of the accident.
- get approval from us before you begin any treatment, except for emergency treatment, to alleviate pain. Charges not reimbursed are your responsibility.
- seek reimbursement under any manufacturer's rebate programs and government programs before sending the claim to us
- 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.
- make sure the treatment begins within 90 days and is completed:
    - in cases where the insured is under 18 years old at the time of the accident, before the insured person turns 19; or
    - within 1 year from the date of the accident.

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

- pay benefits in accordance with the *Dental Association Suggested Fee Guide for General Practitioners*, (not for specialists) 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 termination of either this policy, or your coverage. 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. There is no lifetime maximum. Private ambulance services to a hospital or ambulance services from a hospital to a residence or retirement home aren't covered.

Durable medical equipment

When prescribed by a physician or nurse practitioner, we'll pay for the purchase, lease, or rental of these therapeutic items:

- standard electric hospital bed
- crutches
- cane
- walker
- home oxygen concentrator and oxygen for use at home
- standard non-electric wheelchair
- diabetic supplies including needles, syringes, lancets, and self-monitoring blood glucose test strips

Claims for the purchase, lease or rental of durable medical equipment over $300 must include a completed Prior-Authorization form. 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. We reserve the right to require that you purchase equipment from a preferred supplier.

Exclusions

Benefits **aren't payable** for the following durable 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 including: upholstery, repairs, 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 in excess of 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 durable medical equipment that are outside our guidelines for replacement

Benefits **aren't payable** for the following diabetes-related equipment:

- blood glucose meters
- flash glucose devices and sensors
- continuous glucose monitoring devices, sensors and transmitters
- continuous subcutaneous insulin infusion devices (insulin pumps) and supplies

Hearing aids

Charges for hearing aids prescribed in writing by a physician, nurse practitioner, speech or hearing specialist. Charges for hearing devices must be processed through government assistive devices programs (ADP) first and then sent to us. You must send us a completed Prior-Authorization form, signed by a medical professional. Benefits may be payable up to the maximum amount stated in the Schedule of Benefits and include the initial cost of batteries and repairs to hearing aids.

Exclusions - benefits aren't payable for: medical examinations, audiometric examinations, hearing evaluation tests, replacement batteries.

Medical supplies

Charges for sterile surgical bandages, dressings, or burn jackets used for post-surgery treatment or treatment of open wounds.

Nursing

Benefits include coverage for the medically necessary services of a Registered Nurse (R.N.), Registered Practical Nurse (R.P.N.), Licensed Practical Nurse (L.P.N.), personal support worker, or occupational therapist.

Before services begin, you must send us a completed Prior-Authorization form, signed by a medical professional. We'll advise you of the approval for the type of caregiver and duration of eligible services. We'll also recommend qualified caregivers for homecare or nursing services. Services must include substantive elements of personal care and can only be done in your home.

Exclusions – agency fees, commissions, overtime charges or amounts in excess of usual, reasonable and customary charges as determined by us, services provided by your immediate family, services not authorized in writing by the attending physician or nurse practitioner, or charges incurred by any person who qualifies for similar coverage under a government homecare program.

Orthotics – custom made

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

Paramedical services

Coverage includes charges for the services of these licensed and registered practitioners: massage therapist, speech pathologist, chiropractor, osteopath, chiropodist, podiatrist, acupuncturist, registered dietitian, or naturopath. Benefits are payable only after you reach the yearly maximum allowed under any applicable government health insurance plan. Written authorization from a physician or nurse practitioner may be required.

Physiotherapy

Charges for services provided by a licensed, certified, or registered physiotherapist who isn't related to the you and who doesn't have an agreement with a government health insurance plan, up to the usual, reasonable and customary charges for such services. Written authorization from a physician or nurse practitioner may be required.

Psychology or counselling services

Charges for direct counselling services for stress management, emotional problems, learning and behavioural problems, marriage and family counselling, and alcohol and drug abuse provided by a registered psychologist, psychotherapist, psychoanalyst, marriage and family therapist, or social worker.

Dental benefit

Claims for eligible dental care and services outlined below are considered according to the provincial dental associations' fee guides for general practitioners (not specialists) on the date of service. Claims for services in this section must be submitted to any other benefits plans (for example, a government plan or a spouse's policy) before they are submitted to us. We then pay the claims according to the maximum amounts shown in the Schedule of Benefits. We don't pay any claims for expenses done outside your home province or territory or that are done before the start date of this policy.

Alternate benefit provision: we reserve the right to consider alternative procedures, services, courses of treatment, and materials. We may pay claims based on a less costly treatment that gives a professionally adequate result, consistent with accepted standards of dental practice. The fact that a similar procedure, service, course of treatment, or material was previously used has no bearing on this decision.

Ongoing maintenance services

- examinations
- diagnostic services
- preventive services, including select extractions'
- pit and fissure sealant – on permanent molars only (up to and including age 15)
- restorations, including bonded amalgams
- scaling
- root planning

Oral surgery, endodontic services, periodontal services (Dental 2 and 3 plan only)

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

Major restorative (Dental 3 plan only)

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

For major restorative services, the dentist must send us a treatment plan and x-rays before any work begins. We'll review the x-rays and treatment plan and respond to advise if the services are covered under the plan.

If a major restorative service is eligible under the plan, the associated laboratory fees for that service are also eligible.

Vision benefit

We'll consider the expenses outlined below when they are prescribed by an ophthalmologist or optometrist and dispensed by an ophthalmologist, optometrist, or optician. The maximum for these benefits is shown on your Schedule of Benefits.

- prescription eyeglasses, lenses, or frames
- contact lenses
- laser eye surgery
- optometrist visit or eye exams after any applicable maximums are met under government health insurance plans

Exclusions - industrial and prescription safety glasses, non-prescription sunglasses, services or supplies that aren't for your personal use, eyewear cleaning supplies and accessories.

Prescription drug benefit

Refer to your Schedule of Benefits for specific coverage amounts. Some prescription drugs and medicines might require pre-approval from us.

We pay claims for drugs that appear on our formulary at the time of the purchase. The drugs must be prescribed by a physician, nurse practitioner, or a dentist and dispensed by a pharmacist. Drug 1 and 2 plans only cover the cost of a generic equivalent of a drug, even if the name brand is prescribed. We consider drug expenses according to the lowest cost of the generic equivalent and pay claims subject to the maximums and co-payment percentages shown on the Schedule of Benefits.

Drug 3 plans include brand name drugs or the lowest cost generic equivalent. All drugs and medicines must also appear on Manulife's Formulary.

We don't pay claims for the following, even if they are prescribed by a doctor or dentist:

- vitamins (other than injected vitamins), vitamin/mineral preparations, food supplements, and general public (G.P.) products, whether or not prescribed;
- injected vitamins for weight loss purposes and chelation therapy;
- drugs paid for by any government plan;
- drugs not approved for legal sale 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 in excess of a 3-month supply, unless prior approval has been given by the insurer, or
    - covers a period for which the insurer has not received premium payments;
- assisted conception;
- birth control, if excluded in your Schedule of Benefits; and
- any exclusions outlined in the counter-offer, if applicable.

Preferred hospital accommodation benefit (Drug 2 and Dental 3 plan only)

We pay claims for daily room charges for semi-private (2 beds) or private room (1 bed) when you're hospitalized for sickness or injury, up to the amount shown on the Schedule of Benefits.

We cover up to 2 days in the hospital for pregnancy-related issues or complications if you're less than 21 weeks pregnant on the application date. If you're more than 21 weeks pregnant on the application date, there is no coverage for pregnancy-related issues or complications.

Exclusions - we don't pay claims when you stay in:

- private hospitals.
- chronic care hospitals.
- chronic care units within hospitals.
- transition wards within hospitals.
- slow-stream rehabilitation facilities.

Accidental death and dismemberment benefit

This benefit is payable for accidental death or a loss directly resulting from accidental bodily injury. The loss must occur within 365 days from the date of the accident. Your estate receives the accidental death payment, unless you designate a beneficiary or previously specify otherwise in writing. Payment for all other losses are made to you.

If you suffer more than one loss because of an accident, we limit the payment to the greater of the amounts stated for any single loss due to any one accident.

To claim this benefit, the person entitled to the death or dismemberment benefit should contact us directly. We'll explain which claim forms and other documents we require to pay the correct amount to the right person.

Exclusions – We don't pay claims resulting from or associated with, any of the following:

- self-inflicted injury
- suicide or attempted suicide
- sickness or disease
- terrorism, war, civil disorder or riot;
- committing or attempting to commit a crime
- operating a vehicle under the influence of drugs, toxic substances or an alcohol level over the applicable legal limit;
- 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
- participation in professional sports or any speed contest using a motorized vehicle
- parachuting, hang gliding, bungee jumping, mountaineering, cave exploring
- SCUBA diving, unless you hold a basic SCUBA designation from a certified school or other licensing body

Survivor benefit

Following the death of the policy owner, coverage for the remaining insured persons is maintained and the payment of premiums waived for 1 year.

Hospital cash benefit

If you're hospitalized because of sickness or injury and placed in ward accommodation, we'll pay the amount shown on the Schedule of Benefits.

Exclusions – we don't play claims when you stay in private hospitals, chronic care hospitals, chronic care units within hospitals, transition wards within hospitals, or slow-stream rehabilitation facilities.

3 General exclusions

This section outlines expenses that aren't covered by this plan. In addition to any other exclusions mentioned in this policy, we won't pay claims for charges:

- resulting from self-inflicted injury
- that are eligible under a government health insurance plan or manufacturer's rebate program
- for care, services, or supplies for cosmetic purposes, except when the charges are associated with reconstructive surgery because of disease or bodily injury
- for drugs, tests, services, treatment, or supplies that are not medically necessary, or we consider experimental
- for pandemic screening tests
- higher than those in our guidelines, more than we consider to be usual, reasonable, and customary, or charges for devices not appearing on our list of approved devices
- if you're in the hospital on the effective date of this policy, except when you're hospitalized because of an emergency that happened after the application date of this policy
- for services, equipment, and supplies provided by chronic care or psychiatric hospitals or institutions, chronic care units within hospitals, psychiatric units within hospitals, long term care facilities, or transition wards of acute care hospitals
- for sickness, injury or loss where the law does not allow us to make payments
- for duplicate or replacement prosthetic appliances, devices, or durable medical equipment that are outside our guidelines for replacement;
- charges for duplicate or replacement prosthetic appliances, devices, or durable medical equipment that are outside our guidelines for replacement
- an act or accident of war declared or undeclared, or due to any type of military conflict including acts of terrorism.
- no longer covered under government programs after the effective date of this policy
- for drugs, medicines, services, or supplies that are self-prescribed, prescribed for family members, or prescribed by your relative
- for sickness, injury, or loss that are related to medical conditions shown in the counter-offer letter, signed and accepted by the policyholder, where applicable
- for pregnancy or pregnancy-related conditions if you're more than 21 weeks pregnant on the application date of this policy. If you're less than 21 weeks pregnant on the application date, Manulife pays hospital charges up to a maximum of 2 days if you're hospitalized for pregnancy or pregnancy-related complications
- services, supplies, devices or items that don't qualify as medical expenses under the *Income Tax Act* (Canada), unless covered under this policy

4 How to make a claim with us

When you bought this extended health care policy, we agreed that if you pay your premiums, we would provide you with insurance coverage according to the terms and conditions of this policy. All the people insured under this policy might not be eligible for all the benefits listed in this policy.

Some benefits require you to send us a Prior Authorization form signed by a medical professional prior to obtaining the service. This allows us to make recommendations for services and lets you know in advance how much your benefits will cover for these expenses.

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. All benefits and amounts are in Canadian dollars and don't gather interest.

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

- according to usual, reasonable, and customary charges determined by us.
- within the maximums of your policy.
- according to any exclusions, limitations, conditions, and amendments to this policy.
- if the care, services, or supplies are determined medically necessary by us and are prescribed by a physician, nurse practitioner, dentist, denturist, or other licensed health care professional.
- that aren't available through a government health insurance plan.
- that are payable according to law.
- when we receive all requested written proof within 12 months of the expense. For example: original receipts.

Exclusions - we won't pay claims for charges for:

- 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 any other government regulatory body;
- services, supplies or treatments that aren't generally recognized by the medical profession in Canada as appropriate, effective, or required for 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.

When is a Prior Authorization form needed?

When you get prior authorization for a product or service, you'll know how much of a benefit payment you can expect before paying for it. In some cases, we'll make recommendations for services in your area and may refer you to a preferred provider. You must send us a Prior Authorization form, signed by a medical professional and vendor representative, 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 durable medical equipment over $300
- 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,
PO 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.

Register online

To get the best possible benefit claim experience, enter your email and banking details when you sign up on SecureServe®. Find the plan and identification numbers on your benefits card or previous claim statements. If you don't have either of these, contact the support centre by email at: more_info@manulife.ca, or phone: 1-877-261-8222. Once you have your plan and identification numbers, follow these steps:

- Go to manulife.ca/secureserve and click on "Sign in".
- Scroll down to "Register now" and fill in the information requested.
- You'll be directed back to the sign-in page after you've registered.
- You'll be asked to accept the Terms & Conditions and set up personal verification questions on your first time accessing your online account.
- To register for direct deposit, click on "Banking information". Enter your information and save it.

How to submit a claim online

You'll get your money back faster with online claims and direct deposit. To submit your online claim:

- Obtain a receipt from your service provider that includes their name, contact information, address, and registration number. If you have received prior authorization from us, include this documentation with your claim.
- Go to the website: manulife.ca/secureserve and click on "Sign in".
- Under the "Claims" tab, click "Submit a Claim".
- Follow the steps to submit your claim.

You'll receive an email confirmation when we receive your claim, and a separate notification when we process your claim and deposit the claim payment to your bank account.

How to submit a paper claim

Sending your claims online at manulife.ca/secureserve is the fastest way to process your claims. If you haven't registered yet, you can mail your claim to us for reimbursement, but this process takes a little longer to get your benefit payment to you.

- Go to the website: manulife.ca. Scroll down to "Health and dental" and click on "Mail a paper form".
- Print and complete the "Extended health claim form".
- Attach your receipts and supporting documentation.
- Mail it to the address on the form.

Dental claims

Direct from provider - Most dental offices now submit claims directly to us for reimbursement. Show your dental office your benefit card to confirm coverage for the services provided. If you've entered your banking details at manulife.ca/secureserve, we'll notify you by email when we deposit your claim benefit directly into your account. An explanation of benefits (EOB) is available online.

Non-direct online claim - If your dentist doesn't submit claims directly to us, they'll complete the standard Canadian Dental Association (CDA) dental claim form. You can then submit the claim to us either online or by mail.

- Online: Go to the website: manulife.ca/secureserve, and attach a scan of the CDA claim form. You'll receive your benefit by direct deposit. Your explanation of benefits (EOB) is available online.
- Mail: If you haven't yet registered at manulife.ca/secureserve, you can go to our website: manulife.ca to download and print a claim form. Mail the **original** completed Canadian Dental Association (CDA) dental claim form with the Manulife claim form to: Manulife Financial, Individual Insurance, PO Box 670, Station Waterloo, Waterloo, Ontario N2J 4B8. If we owe you any money, we'll send a cheque in the mail, along with an explanation of benefits (EOB). Remember to keep a copy for yourself.

5 General provisions

additions or changes to coverage: A policy owner may change from single to family coverage at any time by submitting a written application and, if required, medical evidence for the spouse or dependents to be added. Upon approval, coverage becomes effective on a date determined us. When coverage is in force, a spouse or dependent may be added to the policy by submitting notification either online or by mail, and if required, medical evidence within 30 days of the spouse or dependents first becoming eligible. Evidence of health isn't required for a newborn child if the application is submitted within 30 days following the date of birth.

Only one spouse may be covered under a plan at any given time.

Note: The primary insured may not be changed to another person.

applications: If we revise or replace this policy, rates, or provisions, all applications made after that date are considered as applications for the revised or replaced policy and coverage. Policies are issued according to the updated rates and provisions. We or a distribution outlet approved by us must validate all applications.

beneficiary designation: The right of any person to designate persons to whom or for whose benefit insurance money is to be payable is restricted to money payable in event of death.

change of premiums or benefits: We may change the premiums for this policy or revise benefits if we provide 30 days written notice to the policyholder.

claims payments: We make payments for eligible expenses by direct deposit or by cheque to the policy owner or a service provider within 60 days. Exception: If the policy owner dies, we pay the claims to the owner's estate. All benefits and amounts are in Canadian dollars and don't gather interest. If we overpay for a claim or pay a claim in error, we may ask for repayment of the overpayment or amount paid in error, or we may subtract these amounts from claims we pay in the future.

conversion privilege: Coverage may be continued under a separate policy when coverage terminates for an insured person due to divorce; or when a dependent turns age 21; gets married; becomes an orphan; or obtains full-time employment. To maintain conversion privileges, you must contact us within 30 days of coverage termination.

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 exceed 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 1 plan.

coverage: All people insured under this policy must maintain the same coverage.

effective date: This policy begins on the effective date shown on the Summary of Information page.

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

- have coverage under your government health insurance plan;
- be a resident of Canada in any province or territory, except Quebec;
- be a participating CAA member on the application date; and
- be at least 18 years of age on the date of application for this policy, except for dependent children of a member.

If we decide that you or anyone else on the policy was not or isn't eligible, we may terminate the policy immediately without refunding premiums. We may also ask you to repay us for any claims we might have paid after we told you about terminating your policy.

increased or reduced coverage: At any time, a policyholder may submit a written application and evidence of good health to apply for an increase in coverage from Manulife.

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

limit of liability: We're only liable to pay benefits according to the terms and conditions of this policy. We aren't responsible for:

- the quality or results of any medical treatment, care, supplies, or services a third party offers
- the unavailability of any medical treatments, care, supplies or services 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, set-off and indemnification: If, within 2 years of the effective 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 covered under the policy, we may either cancel the entire policy, modify or end coverage only for those people to whom the failure to disclose relates, while maintaining coverage for the remaining individuals insured under the policy, provided such remaining insureds aren't obligated to continue coverage in this manner.

In addition, we have the right to set off against the amount we're required to return on account of eligible premiums the amount of any claims we've already paid. However, after coverage has been in force for a period of 2 years, we can't void any coverage, unless a fraud is committed.

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

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

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

multiple policies: You can't be covered by more than one Manulife individual health and dental plan at a time. Additionally, you can't be covered under successive Manulife health and dental plans that were issued within 24 months of the prior plan's termination.

If we determine that you are covered under more than one policy at the same time, or under successor policies, we may provide notice and cancel one, more, or all the policies immediately without a refund of premiums. We reserve the right to recover any claims paid under any of the policies involved.

non-transferable: This policy may not be transferred to another person or family member.

notice to insurer: to send us notices and documentation online go to the website: manulife.ca and click on Contact us. You may also notify us by mail to: Manulife, Affinity Markets, PO Box 670, Station Waterloo, Waterloo, Ontario N2J 4B8, Attention: Policy Service Department.

premium payments: This policy remains in force from month to month if the necessary premiums are paid on time. Coverage ends at the end of the last month premiums were paid to and accepted by us. In this case, no notice is required. If payment is returned for insufficient funds (NSF), a $25.00 administration charge applies.

provincial variations: If necessary, we adjust the provisions described in this policy to meet the minimum requirements of law within your province or territory.

reporting of termination: If you choose to end your coverage, you must notify us in writing. Where termination is for a specific event, including moving to the province of Quebec, death, divorce, a dependent child becoming married, or a dependent child becoming employed on a full-time basis, it must be reported to us within 30 days. If we aren't notified of the termination within 30 days, any refunds of premiums for deceased or ineligible insured persons is limited to a maximum of 12 months.

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

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 partners may ask for relevant information from physicians, nurse practitioners, dentists, hospitals, clinics, and service providers.

scans: A scanned image or PDF of your application and any applicable medical forms are as good as and as binding as the original. This doesn't apply to receipts as originals must be sent when requested.

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.

waiver: 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.

6 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: We will, upon request, furnish to the policyholder or to a claimant under the contract a copy of the application.

material facts: No statement made by the policyholder or insured persons at the time of application for this contract can 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 policyholder or 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, or by sending it by registered mail to the office of Individual Insurance; or
  - by delivery 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 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, give us a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which a 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.

insurer to furnish forms for proof of claim: We will provide forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time you may submit your proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim, and of the extent of the loss.

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

- you will give us an opportunity to examine the insured person when and so often as is reasonably required while the claim is pending; and
- in the case of an insured person's death, we may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

when moneys payable: All moneys payable under this contract, are to be paid by us within 60 days after we receive proof of claim.

7 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 due exclusively to an external cause inflicting, directly and independently of all other causes, 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. An active treatment hospital also has a laboratory and operating room (on the premises or in facilities controlled by the hospital) where surgical operations are performed by a legally qualified surgeon. Active treatment hospitals do not include any hospital or institution or part of such hospital or institution licensed or used principally as a clinic, chronic care, extended care facility, convalescent home, rehabilitation centre, rest home, nursing home, home for the aged, health spa, or treatment centre for drug or alcohol abuse.

act of terrorism or terrorism - any activity that involves a threat to use or the actual use of violence or any dangerous or threatening act, or the use of force. Such act is directed against the general public, governments, organizations, properties or infrastructures, or electronic systems. The intention of such activity is to: instill fear in the general public; disrupt the economy; intimidate, coerce or overthrow a sitting government or occupying power or; promote political, social, religious or economic objectives.

anniversary year - the consecutive 12-month period following the start date of the policy, and each 12-month period thereafter.

application date - the date when the application was received 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 is attached to the body or any part of the body, excluding any brace that is used to correct a dental defect, deficiency, or injury.

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 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 about possible further testing or surgery.

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

dentist or 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.

drug formulary – a continuously updated list of approved prescription drugs covered under a supplemental health insurance plan. This list of drugs is determined by a combination of medical research, physician analysis, and clinical outcomes.

effective date - the day when the coverage under this policy begins. Also known as the start date.

eligible expenses – products or services that you pay for and are eligible for repayment by us based on the provisions, terms, limitations, and exclusions of this policy.

emergency - an acute, unexpected, or unforeseen illness or accidental injury that 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 - benefits are available to a maximum of 2 adult insureds aged 18 and older, and eligible children identified on the application form.

formulary –see drug formulary.

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 provider whose occupational duties include treatment, advice, consultation, diagnosis, or hospitalization, and who is not you, or your immediate family member.

hospital - a public hospital licensed under the *Public Hospitals Act* or similar legislation of a province or territory, recognized by the Ministry of Health of a province or territory as a public hospital, or a duly licensed general active treatment facility in another jurisdiction. Unless stated otherwise in this policy, a hospital does not 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 you 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 - your spouse, children, parents, and siblings.

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

inpatient - a person confined to a hospital for more than 24 consecutive hours, on the recommendation of the attending physician or nurse practitioner.

insured or insured person - a maximum of 2 people, aged 18 years or older, covered under this policy and a government health insurance plan, providing premiums are paid. May also include dependent children listed on the application for this policy.

insurer - The Manufacturers Life Insurance Company (Manulife).

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, and total and irrevocable loss of all sight.

medical professional –physicians, nurse practitioners, nurses, and other health care specialists who provide medical care in the jurisdiction, as well as their various governing bodies, associations, and other interested groups including but not limited to: The Ministry of Health, The College of Physicians and Surgeons, or similar bodies in the province or territory, and the relevant provincial 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 attending physician or nurse practitioner prescribes the service or supplies doesn't automatically mean they are medically necessary and covered by the policy.

minor ailment - any condition that doesn't require medication for a period longer than 30 days, a follow-up or referral visit to a registered medical practitioner, hospitalization, or surgical intervention.

nurse- a person medically trained and registered in the jurisdiction where the service is provided to provide care and follow a code of ethics and conduct. They are not you or your immediate family member.

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 you or your 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 options you chose.

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 contract, including the application for insurance, any attached documents, and any future amendments.

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

policy owner - the person who this policy was issued to and with whom Manulife has entered into an insurance contract. Also known as the policyholder.

primary insured – 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 – meets the definition in the *Private Hospitals Act of Ontario* and licensed by the Ministry of Health as such, or an equivalent hospital outside Ontario.

Registered Nurse (R.N.) - a person who holds a certificate as a Registered Nurse (R.N.) under the *Health Disciplines Act* or similar legislation in their province or territory or who is registered or licensed in another jurisdiction to provide services which are equivalent to those provided by an R.N. and isn't you, an immediate family member, or a Registered Practical Nurse (R.P.N.).

Registered Practical Nurse (R.P.N.) or Licensed Practical Nurse (L.P.N.) - a person who is licensed, certified, or registered as such in the area where the services are provided, and who is not you or your immediate family member.

resident - a person who has a valid provincial health insurance card number, maintains a permanent place of residence in Canada, and who has been in the country for a period of no less than 183 days during the past 12 months.

scans: an image or PDF of your application, any applicable medical documentation, or Prior-Authorization form is as good as and as binding as the original. This doesn't apply to receipts, as you must give us originals 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.

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.

usual, reasonable and customary – in relation to charges:

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

vehicle - a passenger automobile, motorcycle, motor home, truck, RV, and all Class A, B, and C vehicles under 11 metres (36 feet) long, provided that the vehicle is not licensed to carry passengers for hire.

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