Manulife

The Manufacturers Life Insurance Company

The Association Health and Dental Plan

The coverage evidenced by this policy commences on the effective date shown in the attached Summary of Information page.

In consideration of the application by the policyholder and payment of the required premiums, benefits are provided by The Manufacturers Life Insurance Company (Manulife) (hereinafter referred to as the insurer).

The insurer will pay benefits subject to the terms, conditions and limitations of this policy.

PREMIUMS: The premium is due in advance of the effective date and thereafter on a date determined by the insurer.

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 at Toronto by:

Roy Gori,
President and Chief Executive Officer

Table of contents

Please note: Some of the terms used in this policy have been assigned a specific meaning and it is very important that this policy be read and understood with these specific meanings in mind. A list of these terms is found in the Definitions section in Part F of the policy at the back and it is highly recommended that you familiarize yourself with these terms and their associated meaning whenever consulting this policy.

Important: This policy contains exclusions, limitations, conditions, deductibles, maximums and definitions. Please read it carefully.

Part A: Payment of benefits

If an insured incurs eligible expenses for care, services or supplies as described in this policy, or suffers a sickness, injury or other loss for which benefits are payable hereunder, the insurer will pay those benefits subject to the exclusions, limitations and conditions stated in this policy, and/or amendments to this policy.

Notwithstanding the foregoing, benefits are payable only to the extent that:

a) the eligible expenses for which they are being claimed are usual, reasonable and customary as determined by the insurer, and are within the maximum amount stated in the policy or in the Schedule of Benefits attached to this policy;
b) the care, service or supplies for which they are being claimed are medically necessary and were provided or prescribed by a Physician, Nurse Practitioner, Dentist, Denturist or licensed health care professional, where required under this policy;
c) they are not prohibited by law and are not available under any government health insurance plan;
d) written proof of claim satisfactory to the insurer is submitted within twelve (12) months from the date the charges were incurred or the event giving rise to the claim occurred.

Part B: Health care benefits

The following is a description of the health care benefits available under this policy. Benefits are subject to 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 for details of coverage selected.

Extended health care benefit

Payments for care, services or supplies listed in items 1-13 under this section are subject to the maximum amounts stated in the Schedule of Benefits for this policy. Participation in available manufacturers' rebate programs and government programs is mandatory for all applicable benefits.

1. **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, provided the injury is sustained after the effective date.

   The insured must:

   a) notify the insurer of the injury within ninety (90) days from the date of the accident;
   b) ensure that treatment is commenced within such ninety (90) day period and be completed:
      i) in cases where the insured is less than 18 years of age at the time of the accident, prior to such person's attainment of age 19; or
      ii) in all other cases, within one year from the date of the accident.

   No payment will be made for charges incurred after the termination date of this policy or after the termination date of the insured's coverage under this policy. Payment will be made in accordance with the Dental Association Suggested Fee Guide for General Practitioners in effect on the date of treatment for your province or territory of residence.

   Pre-determination of Dental Accident Benefits: A written estimate must be obtained from the attending dentist, containing details of the accident, pre-accident condition of the teeth, planned treatment and cost.

   The insurer will review the estimate and advise the insured as to the amount of the benefit payable. Approval must be obtained from the insurer prior to commencement of treatment (except for such emergency treatment as is immediately required to alleviate pain).

Alternate Benefit Provision: The insurer reserves the right to take into account alternative procedures, services, courses of treatment and materials, and to provide benefits based on the least costly thereof 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 shall have no bearing on this provision.

Where a range of fees, laboratory charges or other individual considerations are included, the insurer will determine the amount payable.

Charges not reimbursed by the insurer are the responsibility of the insured.

2. **Ambulance Services:** Charges for medically necessary emergency professional ambulance services for ground and air conveyance to a hospital, up to the difference in amount between the government health insurance plan allowance and the usual, reasonable and customary charges for such services, as determined by the insurer.
3. **Physiotherapy:** Charges for the services of a licensed, certified or registered Physiotherapist who is not a relative of the insured and who does not have an agreement with a government health insurance plan, up to the usual, reasonable and customary charges for such services.
4. **Medical Supplies:** Charges for sterile surgical bandages, dressings or burn jackets to be used for post surgery treatment or treatment of open wounds.
5. **Paramedical Services†*:** Charges for the services of a Registered Massage Therapist, Speech Pathologist, Chiropractor, Osteopath, Chiropodist, Podiatrist, Acupuncturist, registered Dietitian or Naturopath.

   *Benefits are payable only after the yearly maximum allowed under the government health insurance plan has been reached, if applicable.

6. **Psychology Benefit (Counselling Services)†:** Charges for direct counselling services rendered by a registered Psychologist, Clinical Counsellor, registered Psychotherapist, registered Marriage & Family Therapist, or registered Social Worker for stress management, emotional problems, learning and behavioural problems, marriage and family counselling, and alcohol and drug abuse.
7. **Durable Medical Equipment:** Charges for purchase, lease, or rental of items listed below, when prescribed by a Physician or Nurse Practitioner, for therapeutic use only, subject to the exceptions thereunder:
   - standard electric hospital bed
   - crutches
   - cane
   - walker
   - home oxygen concentrator and oxygen for use at home [1]
   - standard manual wheelchair [1]
   - diabetic supplies including needles, syringes, lancets, and self-monitoring blood glucose test strips [2]

   [1] Benefits **are not 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, 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

   [2] Benefits **are not 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

For durable medical equipment claims exceeding $300, the insured must send to the insurer a written estimate that outlines the purchase, lease, and rental charges for the equipment. The insurer will 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 the insured to use it exceeds the price to purchase the equipment, the insurer may choose to pay the initial purchase price for the item instead of rental charges.

8. **Prosthetic Appliances†:** Charges for the purchase of the following:

   standard artificial limb (if a myo-electric or sport prosthesis is selected, payment shall be limited 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.

   † Requires written authorization from a Physician or Nurse Practitioner.

9. **Orthotics†:** Charges for the purchase of custom-made orthotics (plaster cast or computer topography).

   † Requires written authorization from a Physician, Nurse Practitioner, or Podiatrist/Chiropodist.

10. **Lifeline® Personal Response Service:** Charges for Lifeline Personal Response Service, provided that the maximum covered period for this service is stated in the Schedule of Benefits. Lifeline Personal Response Service provides 24-hour monitoring service for people coping with medical problems at home. The insurer cannot guarantee the availability of this benefit indefinitely.
11. **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;
    b) Occupational Therapist.

    Benefits shall be payable if the services are certified as medically necessary by the attending Physician or Nurse Practitioner, approved by the insurer and are performed in the insured's home.

    The insurer is able to recommend qualified caregivers for homecare or nursing services. It is required that requests for homecare or nursing services be made prior to the commencement of services in order to ascertain the type of caregiver and duration of eligible services which will be approved. Services must include substantive elements of personal care in order to receive approval.

    The maximum amounts payable for homecare and nursing are stated in the Schedule of Benefits. Benefits are not payable for agency fees, commissions, overtime charges or amounts in excess of usual, reasonable and customary charges as determined by the insurer, services provided by a relative of the insured, 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.

12. **Hearing Aids:** Charges for hearing aids purchased on the written prescription of a Physician or Nurse Practitioner, speech or hearing specialist. Benefits may be payable up to the maximum amount stated in the Schedule of Benefits, and shall include the initial cost of batteries and repairs to hearing aids.

    Benefits are not payable for:
    a) medical examination, audiometric examination, or hearing evaluation tests; or
    b) replacement batteries.
13. **Diagnostic Services (only available to residents of Quebec).** Charges for the following 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 as stated in the Schedule of Benefits.
- 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.

Dental benefit

The insured will be reimbursed for charges incurred for dental care or services, as outlined below, provided the charges do not exceed the amount stated in the Provincial Dental Association Suggested Fee Guide for General Practitioners in effect at the time the services are rendered. Benefit payments under this section are subject to the co-payment first and then to the maximum amount as stated in the Schedule of Benefits. Benefits are not payable for charges incurred prior to the effective date.

Alternate Benefit Provision: The insurer reserves the right to take into account alternative procedures, services, courses of treatment and materials, and to provide benefits based on the least costly thereof 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 shall have 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

Endondontic services

Adjunctive services

Anaesthesia

Space maintainers

Denture repair/reline/rebase, adjustments

Periodontal services

Major Restorative

Dentures, including premium dentures, reimbursed at non-premium fees Crowns, including bonded crowns reimbursed at non-bonded fees

Bridges

Orthodontic

In the event that charges for services under Major Restorative are needed, it is necessary to submit a treatment plan completed by your dentist and x-rays, before any work or treatment begins. You will then be advised of the eligibility of the treatment.

Whenever one of the covered services requires in-office and/or commercial laboratory services or study models, its fees will be included.

Accidental death & dismemberment benefit

This benefit will be payable 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:

a) self-inflicted injury;
b) suicide or attempted suicide;
c) sickness or disease as a cause or effect;
d) terrorism, war, (whether or not war was declared) or participation in any civil disorder or riot;
e) committing or attempting to commit a criminal offence;
f) 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.);
g) a flight accident, unless riding as a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more; or
h) 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, the insurer will consider charges incurred by an insured for:

a) prescription eyeglasses (lenses and/or frames);
b) contact lenses;
c) Optometrist visit.

The maximum payable is specified in the Schedule of Benefits.

The insurer will not pay benefits for:

a) safety glasses or non-prescription sunglasses;
b) services or supplies which are not for the personal use of the insured.

Survivor benefit

This benefit provides that, for a period of one (1) year following the death of an adult insured, coverage in favour of a remaining adult insured and/or eligible dependents will be maintained and the payment of premiums waived.

Prescription drug benefit

(See Schedule of Benefits for Specific Coverage Amounts)

(For Quebec Residents Only)
For prescription drugs and medicines that appear on the List of Insured Drugs covered under the basic drug insurance plan administered by the Régie de l'assurance maladie du Québec (the RAMQ List) and on Manulife's Formulary (Mandatory Generic), the insured will be reimbursed for the costs not covered under the basic plan (except for amounts not covered where a generic equivalent is available), provided such drugs and medicines are purchased on the prescription of a Physician, Nurse Practitioner, or Dentist and dispensed by a licensed Pharmacist. Please see the Schedule of Benefits for further details.

For prescription drugs and medicines that do not appear on the RAMQ List but appear on Manulife's Formulary (Mandatory Generic), the insured will be reimbursed the applicable amount set out in the Schedule of Benefits, provided that such drugs and medicines are purchased on the prescription amount set out in the Schedule of Benefits, provided that such drugs and medicines are purchased on the prescription of a Physician, Nurse Practitioner, or Dentist and dispensed by a licensed Pharmacist, it being understood that the amount payable will be determined based on the lower of the actual cost or the lowest cost generic equivalent. Some drugs and medicines might require pre-authorization.

(For Residents of All Other Provinces and Territories)
For prescription drugs and medicines that appear on Manulife's Formulary (Mandatory Generic), the insured will be reimbursed the applicable amount set out in the Schedule of Benefits, provided that such drugs and medicines are purchased on the prescription of a Physician, Nurse Practitioner, or Dentist and dispensed by a licensed Pharmacist, it being understood that the amount payable will be determined based on the lower of the actual cost or the lowest cost generic equivalent. For the Gold health plan, such drugs and medicines must be listed on Manulife's Formulary. Some drugs and medicines might require pre-authorization.

(Applies to Residents of all Provinces)
Manulife will only reimburse charges for drugs and medicines that are listed in the applicable Manulife formulary or RAMQ List (for Quebec residents) at the time the claim is submitted. The amount to be reimbursed will be determined in accordance with the applicable payment criteria in place at that time.

Benefits are not payable for:

a) vitamins (other than injected vitamins), vitamin/mineral preparations, food supplements, and general public (G.P.) products, whether or not prescribed;
b) injected vitamins for weight loss purposes and chelation therapy;
c) drugs paid for by any government plan;
d) drugs not approved for legal sale to the general public in Canada;
e) erectile dysfunction drugs, smoking cessation aids;
f) that part of any one prescription for drugs or medicines which i) is in excess of a three-month supply, unless prior approval has been given by the insurer, and/or ii) covers a period for which the insurer has not received premium payments;
g) assisted conception
h) birth control (unless stated on the Schedule of Benefits); and
i) any exclusions outlined in the counteroffer, if applicable.

Preferred hospital accommodation benefit

(Not available with the Base or Bronze Health Plans)

If an insured is hospitalized as a result of sickness or bodily injury, the insurer will pay for daily room charges in excess of the standard ward rate made by a hospital for semi-private room (limited to two beds) or private room (limited to one bed) accommodation, up to the amount stated in the Schedule of Benefits.

If the insured is less than 21 weeks pregnant on the application date, the insurer will cover a maximum of two (2) days of hospitalization if hospitalization is a result of the pregnancy or complication of the pregnancy. Coverage for pregnancy or complications of pregnancy will not be recognized if the insured is 21 weeks pregnant, or greater, on the application date.

This benefit does not provide payment for charges incurred for 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

(Not available with the Base or Bronze Health Plans, and not available to residents of Quebec)

If an insured is hospitalized in a hospital as a result of sickness or bodily injury and if the insured has only obtained standard ward accommodation, the insurer will pay the amount shown in the Schedule of Benefits. No benefit will be paid when the insured is confined in a chronic care unit of a hospital or private hospital.

Exclusions

(Applies only to Part B: Health Care Benefits)

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

1. charges which are payable under any government health insurance plan or available manufacturer rebate program;
2. charges for care, services or supplies which are for cosmetic purposes, except when in connection with reconstructive surgery to repair or replace tissue damaged by disease or bodily injury;
3. charges for drugs, tests, services, treatment or supplies which are not medically necessary, or which are experimental as determined by the insurer;
4. charges in excess of those in the insurer's guidelines or those the insurer deems to be usual, reasonable, and customary, or charges for devices not appearing on the insurer’s list of approved devices;
5. charges for hospitalization if the person is confined in a hospital on the effective date, except when the confinement is due to an emergency occurring after the application date;
6. charges for 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 care hospital;
7. charges incurred or sickness, injury or other loss suffered for which payment under this policy is not permissible by law;
8. charges for duplicate or replacement prosthetic appliances, devices, or durable medical equipment that are outside the insurer's guidelines for replacement;
9. charges for eligible services provided outside the province or territory of residence of the insured which are in excess of the amount the insurer would have paid for such services if they were provided in the province or territory of residence determined as of the date the last service was provided outside the province or territory of residence;
10. charges incurred or to be incurred, or sickness, injury or other loss suffered which result, directly or indirectly, from, or are in any manner or degree associated with, or occasioned by war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of, or amounting to, an uprising, military or usurped power, hijacking, any act of terrorism or any action taken in controlling, preventing or suppressing any of the foregoing, including claims which are as a result of, or in any way connected or associated with, such events or causes and regardless of any other cause or event contributing concurrently or in any other sequence thereto.

For the purpose of this exclusion, "act of terrorism" means an act including, but not limited to, the use of force or violence and/or the threat thereof, by any person or groups of persons, whether acting alone or on behalf of or in connection with any organization or government, committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear, or an act that has been determined by the appropriate federal authority to have been an act of terrorism;

11. charges, or part thereof, which, after the effective date, cease to be payable under any government program;
12. charges for drugs, medicines, services or supplies which have been self-prescribed, or prescribed by or for family members;
13. charges incurred or 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 policyholder, where applicable;
14. charges for hospitalization due to pregnancy or pregnancy-related conditions which commence during the ten (10) month period following the effective date. However, benefits are payable only to the extent that if the insured is less than 21 weeks pregnant on the application date, the insurer will cover a maximum of two (2) days of hospitalization if hospitalization is a result of the pregnancy or complication of the pregnancy. Coverage will not be recognized if the insured is 21 weeks pregnant, or greater, on the application date.

Part C: Emergency travel medical care benefits

This benefit is available with the Base Plan, Bronze Plan, Silver Plan and the Gold Plan.

Availability of benefits

The emergency travel medical care 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 as a result of emergency illness or injuries which occur outside the insured's province/territory of residence. Benefits are provided to an overall maximum of $5,000,000 Cdn. per insured.

Please note the following:

- A $100 Cdn. deductible will be applied to all unrelated incidents/claims.
- Expenses must have been incurred due to an emergency that occurred during the period covered as per the Schedule of Benefits. For example, if the period covered is 9 days, expenses must have been incurred due to an emergency that occurred during the first 9 days of your travel. The 9 days period becomes effective at the time of the crossing the border of the insured's province/territory of residence or, if travelling by air, at the time the airplane takes off.
- The insured can take as many trips during the year as he or she wishes, but for each trip, after the period covered is exceeded, you must come back to your province/territory of residence in order to be covered for a new trip.
- For the purposes of this benefit, days are determined on a calendar-day basis, such that 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 will limit benefits hereunder to 70% of eligible expenses to a maximum of $25,000 Cdn. These amounts will be waived in the event of an incapacitating or acute illness or injury and you and/or your travelling companion are unable to phone within the first 24 hours of the incident.

Description of benefits

Coverage not available to persons age 65 and over (See Schedule of Benefits for specific coverage amounts).

Subject to any other provision contained herein, this plan provides up to $5,000,000 Cdn. in total per insured for usual, reasonable and customary charges incurred, during the period of coverage, in the following areas:

1. **Hospital Accommodation:** Charges for hospital room accommodation (not a private room or suite), or for outpatient services provided by an active treatment hospital in excess of the amount paid by the insured's government health insurance plan.
2. **Doctor Bills:** Charges made by a Physician or Nurse Practitioner, in excess of the amount paid by the insured's government health insurance plan.
3. **Private Registered Nurse:** Coverage will be provided to a maximum of $3,000 Cdn. for professional charges of a licensed, private Registered Nurse (not a relative) who performs registered nursing duties, during and immediately following hospitalization, when ordered by the attending Physician or Nurse Practitioner.
4. **Ambulance Services:** Licensed ground ambulance charges for service from the place of illness or accident to the nearest qualified medical facility capable of providing appropriate treatment.
5. **Air Ambulance Services:** The cost of air ambulance to the nearest appropriate medical facility or to a Canadian hospital when approved by the insurer. (All air transportation arrangements must be approved and arranged in advance by the Assistance Centre.)
6. **Paramedical Services:** Payment of up to $300 Cdn. for charges made by a Physiotherapist, Chiropractor, Chiropodist, Podiatrist or Osteopath (including X-rays), when required for emergency treatment.
7. **Diagnostic Services:** Charges for laboratory tests and X-rays prescribed by the attending Physician or Nurse Practitioner.
8. **Treatments:** The cost of whole blood, blood plasma or specialized treatments using radium and radioisotopes are covered, when rendered due to emergency hospitalization.
9. **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, excluding vitamins, patent or proprietary products, when required for emergency treatment. Original, paid receipts must be submitted for claim purposes.
10. **Medical Appliances:** The cost of splints, casts, crutches, canes, slings, trusses, walkers and/or the temporary rental of a wheelchair when prescribed by the attending Physician or Nurse Practitioner, obtained outside the insured's province/territory of residence and required due to an accident or unexpected illness.
11. **Accidental Dental:** Treatment to natural teeth due to an external accidental blow to the mouth or head, up to a maximum of $2,000 Cdn. You must see a Physician or Dentist immediately following the accident. An accident report is required from the Physician, Nurse Practitioner, or Dentist for claim purposes. Benefit maximum shall include all related costs associated with treatment.
12. **Relief of Dental Pain:** Treatment for the emergency relief of dental pain, other than accidental dental, is covered to a maximum of $200 Cdn. Treatment must be rendered at a location at least 200 km from the insured's province/territory of residence.
13. **Air Transportation:** In the event of a medical emergency, the cost of returning the insured to Canada for immediate medical treatment when approved by the insurer and arranged by the Assistance Centre.

    Benefit includes the extra cost incurred for the purchase of the most economical airfare, plus the additional most economical airfare, if required, to accommodate a stretcher, to return the insured to a hospital or nearest appropriate medical facility in Canada.

    When the insurer or commercial airline stipulates that the insured must be accompanied by a qualified medical attendant (not a relative), the insurer will cover the usual, reasonable and customary charges charged by 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. (All air transportation arrangements must be approved and arranged in advance by the Assistance Centre.)

    This benefit assumes that the insured is not holding a valid open-return air ticket. If the air ambulance or air transportation benefit is used, the unused portion of the insured's air ticket must be surrendered to the insurer. 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. (All air transportation arrangements must be approved and arranged in advance by the Assistance Centre.)

14. **Friend/Family Hospital Visits:** The most economical airfare, by the most direct route from Canada, will be reimbursed for one (1) family member or friend to:
    - visit the insured confined in hospital. This benefit requires the insured to have been an in-patient for at least seven (7) consecutive days outside their province/territory of residence, plus the written verification of the attending Physician or Nurse Practitioner that the situation was serious enough to have required the visit;
    - identify the deceased prior to the release of the body, where necessary;
    - attend to the insured's dependent children if they are left alone in the insured's destination as a result of the insured's illness or injury. The insurer will pay for the return home of the family member or friend by the most economical fare. (Arrangements must be made through the Assistance Centre.)
15. **Return of Deceased:** Up to $3,000 Cdn. will be paid towards the cost of preparation and homeward transportation to the province/territory of residence of a deceased insured (this benefit excludes the cost of a coffin) or up to $2,500 Cdn. will be reimbursed towards the cost of cremation and/or burial at the place of death, outside the province/territory of residence of the deceased insured.
16. **Meals & Accommodation:** Expenses will be paid up to $1,500 Cdn. per policy, to a maximum of $150 per day, for the extra costs of commercial accommodation and meals incurred by an insured when return to their province/residence is delayed beyond their scheduled return date due to illness or injury to an insured or a travelling companion. The illness or injury and the fact that the insured or travelling companion are unable to travel must be verified by the attending Physician or Nurse Practitioner. Claims must be supported with detailed receipts from commercial organizations.
17. **Vehicle Services:** Up to $2,000 Cdn. will be reimbursed towards the cost of driving the insured's vehicle, including boat or RV, either private or rental, to the insured's province/territory of residence or the nearest appropriate vehicle rental agency, when the insured or the insured's travelling companion are unable to do so, due to an unexpected illness or injury. Medical certification is required, as well as receipts for costs incurred (i.e., fuel, accommodation, meals, airfares, etc.). If the insured's private vehicle is stolen or rendered inoperable due to an accident, costs will be covered for the most economical airfare, to return the insured's vehicle by the most direct route to their province/territory of residence. An official police report of the theft or accident is required.
18. **Hospital Expenses:** Payment of up to $100 Cdn. per hospital stay, to cover incidental expenses. Paid receipts must be submitted.

Automatic extension of coverage

Coverage for any trip will automatically be extended, without further charge to the insured, for up to seventy-two (72) hours following:

- the hospital discharge date, when return to the insured's province/territory of residence is delayed due to hospitalization of the insured or the insured's travelling companion and coverage for the trip expires after the insured is hospitalized;
- the expiry of coverage for the trip, when return to the insured's province/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 the insured's province/territory of residence is delayed due to the delay of a common carrier (airplane, bus, taxi, train), on which a person covered under this policy is a passenger; or the delay is caused by a traffic accident, or mechanical failure of a private automobile en route to the departure point. Claims must be supported by documented proof of the incident which caused the delay;
- the expiry of coverage for the trip, when return to the insured's province/territory of residence is delayed due to extreme weather conditions, causing hazardous driving conditions. Claims must be supported by documented proof from the local authorities and weather office at the location of delay.

Note: Coverage for any trip expires at 11:59 local time on the last day of the coverage Period or Trip Maximum for Travel benefits, as found in the Schedule of Benefits.

The assistance centre

Help is as near as the phone. Contact numbers are located on the world assistance card, should assistance be required. 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.

The insured must be able to 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.

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.

Any insured who is claiming benefits under this policy, but who did NOT contact the applicable Assistance Centre at the time the medical services were provided, or who is seeking reimbursement of incidental expenses, will be required to:

- complete a Claim Authorization and Release Form;
- submit the completed form with the original detailed invoices and/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. To obtain a Claim Authorization and Release Form, phone 1-800-805-1008.
- An identification number, and individual government health insurance plan card number with version code (if applicable), and the date of birth of the patient, will be required.
- All claims must be submitted within six (6) months of occurrence.
- All pertinent documents should be sent to:
  Manulife Travel Insurance c/o Active Care Management
  PO Box 1237 Stn 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 information not provided may result in a delay in the processing of a claim.

Exclusions

Applies only to Part C: Emergency Travel Medical Care Benefits

In addition to any other exclusions set out herein, the insurer will not pay any benefit or accept any liability for any claims relating, directly or indirectly, to:

1. A condition that is not stable within the consecutive nine (9) month period immediately preceding the date of departure from the insured's province/territory of residence. This means any condition, injury, illness, disease or related complication in relation to which:
   - an insured has had 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 a change in medication (the medication dosage or frequency has been reduced, increased, stopped and/or new medication/s has/have been prescribed) taken 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 and/or are awaiting results for further investigation for that condition during such nine (9) month period.

   This exclusion does not apply to minor ailments or a change in medication where the active ingredient and strength remains the same (i.e. generic).
2. Elective (non-emergency) treatment, service or surgery. This includes, but is not limited to, treatment, service or surgery:
   a) not required for the immediate relief of acute pain and suffering; or
   b) which medically could be delayed until the insured has returned to Canada; or
   c) which the insured elects to have rendered or performed outside Canada following emergency treatment or diagnosis of a medical condition which (on medical evidence) would not prevent the insured from returning to Canada prior to such treatment or surgery.
3. Hospital accommodation at other than an active treatment hospital.
4. Experimental or investigative treatment or drugs.
5. Emergency air transportation which is not approved in advance by the Assistance Centre.
6. 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.
7. Emergency medical care benefits exceeding $5,000,000 Cdn. per insured.
8. Expenses incurred outside of the insured's province/territory of residence, when the insured could have been returned to the insured's province/territory of residence without endangering the insured's life or health.
9. Any insured travelling outside their province/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.
10. Any hospitalization or services rendered in connection with general health examinations for "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.
11. Travel booked or commenced contrary to medical advice or after receipt of a terminal prognosis.
12. Hospital and medical care for full-term childbirth or childbirth that occurs after the 26th week of pregnancy; medical complications after 26th week of pregnancy; or deliberate termination of pregnancy. This exclusion applies to both the insured and the newborn.
13. Any treatment required for a mental or nervous disorder.
14. Services provided by Naturopaths, Optometrists or for cataract surgery.
15. Treatment for abuse of medication, toxic substances, alcohol or the use of non-prescribed drugs.
16. 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.

17. The commission or attempted commission of a criminal act under the legislation of the jurisdiction where the act was committed.
18. 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; hang gliding; bungee jumping; mountaineering; cave exploring; SCUBA diving (unless you hold a basic SCUBA designation from a certified school or other licensing body); or a flight accident (unless the insured is riding as a fare-paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more).
19. Sickness or injuries resulting from war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, hijacking, any act of terrorism or any action taken in controlling, preventing or suppressing any of the foregoing, including claims which are as a result of or in any way connected or associated with such events or causes and regardless of any other cause or event contributing concurrently or in any other sequence thereto.

    For the purpose of this exclusion, "act of terrorism" means an act including, but not limited to, the use of force or violence and/or the threat thereof, by any person or groups of persons, whether acting alone or on behalf of or in connection with any organization or government, committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear or an act that has been determined by the appropriate federal authority to have been an act of terrorism.

Conditions

Applies only to Part C: Emergency Travel Medical Care Benefits

1. Coverage hereunder is 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/territory of residence.
2. Coverage shall be in effect for any number of trips taken during the period of coverage provided the duration of each trip does not exceed the number of days available under the insured's plan.

    For the purposes of this benefit, days are determined on a calendar-day basis, such that the day of departure, the day of arrival and every calendar day in between, are each counted as a day.

3. The insurer will only cover usual, reasonable and customary charges incurred as a result of a medical emergency, provided the services are medically necessary. Detailed accounts covering the hospital and medical services provided and reasonable proof of these expenses shall be submitted to the insurer. Failure to do so will invalidate coverage for such claims.
4. Only charges for emergency medical services incurred while the insured is outside the boundaries of their province/territory of residence, during the term of this policy, will be eligible. Coverage becomes effective at the time of crossing the border of the insured's province/territory of residence or, if travelling by air, at the time the airplane takes off, and expires at the border of the insured's province/territory of residence, or when the airplane lands in the insured's province/territory of residence, on the return home or on the expiry date of this policy, whichever comes first.
5. Pre-approval by the Assistance Centre for all interventions and/or procedures (including all diagnostic imaging, such as MRI [Magnetic Resonance Imaging] and CAT [Computerized Axial Tomography] interventions) is required, except for those performed in extreme circumstances on an emergency basis as life/limb saving measures or as supporting diagnostic aids for life/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, as well as chest X-rays, flat plates of bones and abdominal views, are exempt from pre-approval.
6. The insurer, in consultation with the attending Physician or Nurse Practitioner, reserves the right to transfer the insured to another hospital or return the insured to Canada. Refusal to comply with the transfer request will absolve the insurer of any further obligation or liability.
7. 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.

8. If the air ambulance or air transportation benefit is used, the unused portion of the insured's air ticket must be surrendered to the insurer.
9. No benefits are payable for expenses incurred after the expiry date of this policy, unless during the period of coverage, the insured is admitted to hospital and not discharged prior to the expiry date of the period of coverage.
10. The insured must act at all times to minimize the costs to the insurer.

Part D: General provisions

1. APPLICATIONS: If this policy, its rates and/or provisions are revised or replaced by the insurer, any application made subsequent to the date of such revision or replacement will be deemed to be an application for such revised or replaced policy, and coverage will be issued in accordance with the rates and provisions thereof. All applications must be validated by the insurer or a distribution outlet approved by the insurer.
2. COVERAGE: All insureds under this policy must maintain the same coverage.
3. ELIGIBILITY: To be eligible for coverage under this policy, an insured must:
   a) Be covered under your provincial/territorial health insurance plan;
      Quebec residents must also be registered under the RAMQ Prescription Drug Insurance Plan or have equivalent coverage under a group plan;
   b) Be a resident of Canada;
   c) Be at least 18 years of age on the date of application for this policy (unless a dependent child of a member);

   Where the insurer determines that an insured is /was not eligible for coverage under this policy, the insurer shall have the option to terminate this policy immediately, without any refund of premiums, upon providing notice to the insured of such termination and reserves the right to recover any claims paid hereunder.
4. BENEFIT LEVELS: All benefit levels outlined herein are applied on a per insured basis. Coverage provided depends upon whether the single or family option is purchased, unless otherwise stated.
5. NON-TRANSFERABLE: This policy is not transferable to another person or family member.
6. EFFECTIVE DATE: This policy shall become effective on the effective date, as shown on the Summary of Information page.
7. PREMIUM PAYMENT: This policy shall remain in force from month to month provided that the required premiums are paid when due. Coverage shall terminate at the end of the last month for which premium payment was made to and accepted by the insurer, in which case no notice shall be required. In the event that a payment is returned as a result of insufficient funds, a twenty-five (25) dollar administration charge will be levied.
8. CHANGE OF PREMIUMS/BENEFITS: The insurer reserves the right to change premiums required for this policy and to decrease the benefits for any reason, upon thirty (30) days written notice to the policyholder.
9. MISSTATEMENT OF AGE: The insurer may request satisfactory proof of age for any insured under this policy. If the date of birth was misstated and affects (a) the date on which coverage becomes effective, reduces or terminates; (b) the amount or type of coverage; or (c) any rights or benefits provided under this policy, then the correct date of birth in computing the person's age shall govern and rates shall be adjusted accordingly.
10. INCREASED/REDUCED COVERAGE: A policyholder may apply to increase coverage at any time, provided that evidence of health satisfactory to the insurer is submitted along with a written application for the change in coverage. An insured who wishes to reduce benefits must have been covered under the existing benefits for a period of at least twelve (12) consecutive months prior to the requested date.
11. ADDITIONS OR CHANGES TO COVERAGE: A policyholder may change from single to couple or family coverage at any time by submitting a written application and medical evidence (if such evidence is required) for the spouse or dependent(s) to be added. Upon approval, coverage will become effective on a date to be determined by the insurer. When coverage is in force, a spouse or dependent(s) may be added to the plan by submitting written application and medical evidence (if such evidence is required) within thirty (30) days of the spouse or dependent(s) first becoming eligible; evidence of health is not required for a newborn child if the application is submitted within thirty (30) days following the date of birth. Only one spouse may be covered under a plan at any given time.

12. REPORTING OF TERMINATION: Termination of coverage due to death, divorce, or a dependent child becoming married or employed on a full-time basis, must be reported in writing to the insurer within thirty (30) days following the date of such event.

    If a termination is not reported to the insurer until after the expiry of such thirty (30) day period, any refund of premiums paid on account of deceased or ineligible insureds shall be limited to a maximum of twelve (12) months.

13. CONVERSION PRIVILEGE: When coverage terminates for an insured due to divorce, or for a dependent upon attainment of age 21, marriage, becoming an orphan, or obtaining employment, coverage may be continued under a separate policy. To maintain conversion privileges, you must contact the insurer within thirty (30) days of coverage termination.
14. REAPPLICATION FOR COVERAGE: If the policy has been terminated, a period of twenty-four (24) months must elapse before another application will be considered under any Manulife Individual (non-group) Health Plan.
15. RELEASE OF INFORMATION: As a condition precedent to receiving benefits under this policy, the insured agrees to authorize the release of any information reasonably necessary for the insurer to confirm entitlement to benefits and adjudicate claims. The insurer and its service providers have the authority to obtain the insured's pertinent medical records or information from any Physician, Nurse Practitioner, Dentist, hospital, clinic or service provider.
16. CLAIMS PAYMENTS: Claims payments will be made by direct deposit or by cheque to the policyholder or insured, as appropriate, or to a designated provider, except as otherwise provided due to the death of the policyholder. All benefits and amounts referred to are in Canadian funds and no sum payable hereunder shall bear interest.
17. CO-ORDINATION OF BENEFITS: This plan is classified as a supplemental benefit plan. It covers expenses that are not covered under any other benefit or insurance plan, collectible or not. In the event that the insured is entitled to similar benefits under any other individual or group contract including, but not limited to any government health insurance plan, credit card coverage, private or auto insurance, benefits will be co-ordinated with those plans so claims paid do not exceed 100% of the eligible expenses paid.

    After the benefits payable by government plans have been determined, excess benefits available under this policy will be co-ordinated with those of other contracts or plans if the insured is eligible for similar benefits simultaneously under any other non-government plan, as follows:

    a) If any other plan does not contain a provision for co-ordination with or reduction of benefits payable hereunder, the benefit payable under such other plan will be determined first;
    b) If any other plan contains a provision for co-ordination with or reduction of benefits payable hereunder, the benefits shall be prorated between or among the plans in proportion to the amounts that would have been paid under each plan had there been coverage by only that plan;
    c) The insurer will abide by the co-ordinating coverage guidelines for out of country/province healthcare expenses as set out by the *Canadian Life and Health Insurance Association Inc./Association Canadienne des Compagnies d'Assurances de Personnes Inc.* guidelines.

18. MULTIPLE POLICIES: An insured may not at any time be covered under more than one individual Health and Dental plan issued by the insurer, nor may an insured be covered under successive Health and Dental plans issued by the insurer, where the prior plan is terminated and the successor plan is issued less than twenty-four (24) months thereafter. Where the insurer determines that an insured is covered under more than one policy at the same time, or under successor policies, as noted above, the insurer shall have the right to immediately terminate one or more of such policies, or all of such policies, without any refund of premiums, upon providing notice to the insured of such termination. The insurer further reserves the right to recover any claims paid under any policy under which an insured may have been covered in contravention of the provisions of this paragraph.
19. SUBROGATION: Where the insurer makes any payment or assumes any liability hereunder, it is subrogated to all right of recovery of the insured against any person in relation thereto. The insured shall do nothing to prejudice such right and shall co-operate fully with the insurer should it choose to bring suit in the name of the insured. Notwithstanding this, the insured may choose to exercise such right of recovery by bringing suit directly, in which case he or she shall advise the insurer and shall do all that is necessary to protect the interest of the insurer therein. Unless otherwise agreed, any amounts recovered or received pursuant to or in any way related to the exercise of such right shall be applied first to the retirement of all amounts paid by the insurer at first instance hereunder, less a reasonable amount on account of legal fees incurred by the insured in bringing suit.

20. MISREPRESENTATION, SET-OFF AND INDEMNIFICATION: In respect of any application made hereunder, any misrepresentation, concealment or failure to disclose correct information will, if discovered within two (2) years of the effective date of the policy, render this policy voidable at the option of the insurer, and will limit the liability of the insurer to the return of eligible premiums. Where there are multiple insured under the policy, the insurer may either terminate the entire policy or modify or terminate only the coverage of the individual insured or insureds to whom the failure to disclose relates, while maintaining coverage in place for the remaining individual insureds under the policy, provided such remaining insureds shall not be obliged to continue coverage in this manner. In addition, the insurer shall have the right to set-off against the amount it is required to return on account of eligible premiums the amount of any claims it has already paid. However, after coverage has been in force for a period of two (2) years, coverage shall not, in the absence of fraud, be voidable. In respect of the submission of a claim hereunder, any misrepresentation, concealment or failure to disclose correct information, whether intentional or not, will, at the option of the insurer, result in the insured being responsible for 100% of the amount of the claim, as well as for any costs which may have been incurred by the insurer in investigating the claim. This will include legal costs and any fees or costs paid to a private investigator. Both the insured and the policyholder (if different) shall be jointly and severally liable to indemnify the insurer in this regard and such obligation shall survive any termination of this policy.
21. LIMIT OF LIABILITY: The insurer will not be responsible, without limiting the generality of the foregoing, for the availability, quality or results of any medical treatment, care, supplies or services provided by a third party, including transportation; for any act or omission of any third party providing such care, treatment, supplies or services; or the failure of an insured to obtain medical treatment. The liability of the insurer will be limited solely to the payment of benefits in accordance with the terms and conditions of this policy.
22. NOTICE TO INSURER: Any notice to the insurer must be sent by prepaid post to:
    Manulife, Affinity Markets
    P.O. Box 670, Station Waterloo
    Waterloo, ON N2J 4B8
    Attention: Policy Service Department
23. WAIVER: Waiver by the insurer of its rights in any particular instance will not preclude the insurer from exercising its rights in the same or any other similar situation that may later arise.
24. FACSIMILE: A facsimile or photocopy of the application for this policy and/or medical questionnaire, if applicable, shall be deemed to be an original and shall be as binding on the insured as if it were an original.
25. 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 in the *Limitation Act 2002*, for Ontario.
26. PROVINCIAL VARIATIONS: If necessary, the provisions described in this contract will be adjusted to meet the minimum requirements of law within your province or territory.
27. 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.

Part E: Statutory conditions

1.

   i) The 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.

   ii) Waiver: The insurer shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the insurer.

   iii) Copy of Application: The insurer shall, upon request, furnish to the policyholder or to a claimant under the contract a copy of the application.

2. Material Facts: No statement made by the policyholder or insured at the time of application for this contract shall be used in defence 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.
3.
   (1) Notice and Proof of Claim: The policyholder or an insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall:
      (a) give written notice of claim to the insurer,
         i) by delivery thereof, or by sending it by registered mail to the office of Affinity Markets; or
         ii) by delivery thereof to an authorized agent of the insurer in the province, not later than thirty (30) days from the date a claim arises under the contract on account of an accident, sickness or disability;
      (b) within ninety (90) days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the insurer such proof as is reasonably possible in the circumstances of the happening or 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
      (c) if so required by the insurer, furnish 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.
   (2) 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 (1) 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.
4. Insurer to Furnish Forms for Proof of Claim: The insurer shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim, but where the claimant has not received the forms within that time he may submit his 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.
5. Rights of Examination: As a condition precedent to recovery of insurance moneys under this contract,
   a) the claimant shall afford to the insurer an opportunity to examine the person of the insured when and so often as is reasonably required while the claim hereunder is pending; and
   b) 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.
6. When Moneys Payable: All moneys payable under this contract shall be paid by the insurer within sixty (60) days after it has received proof of claim.

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

Part F: Definitions

Where used in this policy, the term:

accident or **accidental** means an unintentional, sudden, fortuitous and unforeseeable event due exclusively to an external cause inflicting, directly and independently of all other causes, bodily injuries.

active treatment hospital means an institution licensed as a hospital and operated for the care and treatment of resident in-patients 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 and shall not 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.

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

application date means the date the application is/was received at our Affinity Markets office.

benefit year means the consecutive 12 month period following the date a claim is incurred.

brace means a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any brace which is used to correct a dental defect, deficiency or injury.

calendar year means the 12 month period commencing January 1st and ending December 31st.

change in medication means medication dosage or frequency being reduced, increased, stopped and/or new medications being prescribed.

claim means the accumulated eligible expenses, per incident of illness or injury, while this policy is in force, and/or the act of notifying the insurer that eligible expenses have been incurred and the requesting of payment therefor, as the case may be.

claimant means an insured making a claim under this policy.

Clinical Counsellor means a person who provides counselling services to individuals to assist them in understanding issues and concerns about their personal development and mental health. Clinical Counsellors must hold a counselling certification or degree recognized in the province where they are practicing and be registered with a federal or provincial association of counsellors.

consulted means seeking advice or treatment from any Physician, Nurse Practitioner, and/or health care professional for any condition, injury, disease or disorder. This would include discussions of possible further testing or surgery.

co-payment means the percentage of charges eligible as benefits which are payable by the insurer.

Dentist or **Denturist** means a practitioner of dentistry lawfully qualified and licensed to practice in the jurisdiction in which he or she has provided the services or supplies for which the charges are incurred and who is not the insured, or an immediate family member of the insured.

dependent means a child of the insured who is listed on the application and who is a natural child, adopted, stepchild or foster child, or a child for whom the insured is by law responsible, who is unmarried, unemployed and dependent on the insured for financial support and is under 21 years of age.

effective date means the day on which coverage under this policy takes effect.

eligible expenses means expenses incurred by an insured that are payable by the insurer based on the provisions, terms, limitations and exclusions of this policy.

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

experimental means a service, drug, treatment or medical device which has not been approved by The Health Protection Branch of Health Canada for use in Canada or acknowledged as appropriate or acceptable by the medical profession.

family coverage means benefits are available to the adult insured(s) over 21 years of age and dependents identified on the application form.

government health insurance plan means any plan or arrangement provided by or under the administrative supervision of any Canadian government or agency which provides coverage or reimbursement for any health care service or supply, including but not limited to the health insurance plan of the insured's province or territory of residence, homecare program, assistive devices program and the Workers' Compensation Act or similar legislation of the insured's province or territory of residence.

health care professional means any licensed, regulated health professional whose occupational duties include the provision of treatment, advice, consultation, diagnosis or hospitalization.

hospital means a public hospital licensed under the Public Hospitals Act or similar legislation of the province/territory in question, or recognized by the Ministry of Health of the province/territory in question as a public hospital, or a duly licensed general active treatment facility in another jurisdiction. Unless expressly stated otherwise herein, the term 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 means to be admitted to a hospital or an active treatment hospital (as the case may be), as an in-patient.

immediate family member means, for each insured, the spouse, children, parents and siblings of such insured.

injury means unforeseeable harm to the body caused by an accident, provided that the accident occurred while this policy was in force and the harm caused by the accident requires immediate medical treatment which is covered by this policy.

in-patient means a patient confined to a hospital for more than 24 consecutive hours, on the recommendation of the attending Physician or Nurse Practitioner.

insured means a person who is covered under this policy, providing premiums continue to be paid. Each insured must be covered under a government health insurance plan and only two may be eighteen (18) years of age or over.

insurer means The Manufacturers Life Insurance Company.

licensed, certified or registered means licensed, certified or registered by the appropriate authority or professional body in the jurisdiction where the care or services are rendered or the institution exists, provided that "Registered Nurse" shall have the meaning defined below.

loss as used with reference to hand or foot means complete severance at or above the wrist or ankle joint and as used with reference to sight means the total and irrecoverable loss of all sight.

Manulife means The Manufacturers Life Insurance Company.

medical profession means the Physicians, Nurse Practitioners, Nurses and other health care professionals providing medical care in the relevant 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/territory in question, and the relevant provincial medical associations.

medically necessary means any care, service, supply or other matter which is ordered to be provided to an insured by a Physician, Nurse Practitioner, or health care professional and which the insurer determines is:

a) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the insured's illness or injury;

b) provided in accordance with generally accepted medical practice on a national basis; and

c) the most appropriate supply or level of service which can be provided on a cost effective basis.

The fact that the insured's attending Physician or Nurse Practitioner prescribes the service or supplies does not automatically mean such services or supplies are medically necessary and covered by the policy.

minor ailment means any condition not requiring either the use of medication for a period of greater than thirty (30) days, a follow-up or referral visit to a registered medical practitioner, hospitalization or surgical intervention.

Nurse means a Nurse duly registered in the jurisdiction where the service is provided.

Nurse Practitioner means a duly qualified registered nurse who has completed a graduate degree in nursing and is licensed in their jurisdiction to:

- provide direct care to patients in the diagnosis and management of disease and illness
- prescribe medications
- order and interpret laboratory tests, and
- initiate referrals to specialists.

They may not be the insured, or an immediate family member of the insured.

period of coverage means the number of days of coverage according to the plan option chosen.

Physician means a duly qualified doctor of medicine (M.D.) entitled under the laws of the province, state or country where the services are rendered, to practice medicine and surgery without restriction and who is not the insured or an immediate family member of the insured.

policy means this insurance policy, including any documents attached hereto, your application for insurance, and any subsequent amendments.

policyholder means the person to whom this policy was issued and with whom the insurer has entered into a contract of insurance.

private hospital means 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 (R.N.) means a person who holds a certificate as a Registered Nurse (R.N.) under the Health Disciplines Act or similar legislation in his or her province/territory or who is registered or licensed in another jurisdiction to provide services which are equivalent to those provided by an R.N. and does not include the insured, an immediate family member of the insured, or a Registered Practical Nurse (R.P.N.).

Registered Practical Nurse (R.P.N.) or Licensed Practical Nurse (L.P.N.) means a person who is licensed, certified or registered as such in the jurisdiction in which the services are rendered, and who is not a relative of an insured.

resident means 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 not less than 183 days during the past twelve (12) months.

single coverage means benefits are only available to the policyholder or insured, if different from the policyholder.

speed contest means an activity of a competitive nature in which speed is a determining factor in the outcome of the event.

spouse means a person who is covered under a government health insurance plan and to whom the insured is legally married or with whom the insured has cohabited in a conjugal relationship for at least 12 consecutive months.

travelling companion means any person who has prepaid accommodation and/or transportation with the insured for the same covered trip.

treatment means any reasonable medical, therapeutic or diagnostic measure, prescribed by a Dentist, Physician, Nurse Practitioner, or health care professional in any form including prescribed medication, reasonable investigative testing, hospitalization, surgery or other prescribed or recommended medical care directly referable to the condition, symptom or problem.

trip means any excursion taken by an insured outside the insured's province of residence while this policy is in force.

usual, reasonable and customary means, in relation to charges, the usual charge for a service given or supplied by a provider ("usual"); those charges which are consistent with representative fees and prices which would normally be made in the absence of coverage under this policy ("reasonable"); and that range of usual charges by providers with similar expertise and services within the geographic area ("customary").

vehicle means a passenger automobile, motorcycle, motor home, truck, R.V., and all Class A, B & C vehicles under 11 metres (36 feet), providing such vehicle is not licensed to carry passengers for hire.

30-DAY SATISFACTION GUARANTEE

The insured may, within thirty (30) days after receiving this policy, return it to the address below for cancellation. The policy will be considered never to have come into effect and any premium paid up to the end of the 30-day examination period will be refunded, less any claims paid. Where claims paid exceed premiums, the difference must be repaid to the insurer immediately. This right of cancellation expires thirty (30) days after the policy is received by the insured and does not apply to any reissued, substituted or consolidated policy continuing coverage that commenced under a previously issued policy. The rights of any beneficiary under the policy are subject to this right of cancellation.

THE MANUFACTURERS LIFE INSURANCE COMPANY
Affinity Markets
P.O. Box 670, Station Waterloo
Waterloo, Ontario
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