Manulife

Certificate of Insurance
Group Extended Health Care – Dental and Dental Plus

Benefits are administered and underwritten by:

The Manufacturers Life Insurance Company (Manulife)

We administer this Certificate #1777MO, #1777ML, and #1777MP and pay benefits to the person named in the *Summary of Information*, according to the terms, conditions, and limitations of Group Policy #17884, which we have issued to the

Ontario Medical Association (OMA)

This document contains all details about your coverage and how to use it. Your contract includes this Certificate, *Summary of Information, Your Benefits*, applications for insurance submitted by you, and any schedules, riders, attachments, amendments and/or endorsements to this Certificate executed by us. If there is any conflict between the terms and conditions of this Certificate and the Group Policy, the terms of the Group Policy take precedence, to the extent permitted by law.

The effective date, also known as the start date, of this Certificate appears on your *Summary of Information*. Please read this Certificate carefully to become familiar with the features of the coverage so you can take full advantage of the benefits it offers.

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

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

Roy Gori,

President and Chief Executive Officer

30-day satisfaction guarantee

The first 30 days from the start date of your insurance is known as the free-look period. If you decide that you don't want your Certificate, simply mail it to the address below for cancellation. We will cancel your Certificate as of the start date shown on your Summary of Information and send you a full refund of premiums, minus any claims we've paid. If the claims we paid are more than your premium payments, you must repay the difference. This right of cancellation expires 30 days after the Certificate is received by you. The rights of any beneficiary under the Certificate are also subject to this right of cancellation.

The Manufacturers Life Insurance Company
Affinity Markets
P.O. Box 17001, Station Waterloo,
Waterloo, Ontario N2J 0G5

Visit our website: manulife.ca
Email us: more_info@manulife.ca
Call us toll-free: 1-888-596-8881

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Before you begin

This Certificate indicates that your application for insurance under the Group Policy has been accepted by us and, as of the start date shown on your *Summary of Information*, your insurance is in force under the terms and conditions of the Certificate.

To be eligible to submit claims, this Certificate must be in good standing, which means the Certificate premiums must be paid in full to the current date. Each insured person must be enrolled in a provincial or territorial government health insurance plan, where applicable.

We may update our terms and conditions without notice to reflect corporate policies, economic changes, or legislative changes, including changes to income tax legislation. Any changes we make to the terms and conditions may affect the benefits provided by this Certificate. We reserve the right to change premiums or benefits required for this Certificate for any reason.

All benefits outlined in this Certificate apply to each insured person. We only cover usual, reasonable, and customary expenses for medically necessary conditions. This Certificate contains information about your insurance coverage, including exclusions, limitations, conditions, deductibles, maximums, and definitions. Please read it carefully and be sure to keep it in a safe place.

Some of the terms used in this Certificate and the *Your Benefits* document have been assigned a specific meaning. It's very important this Certificate is read and understood with these specific meanings in mind. Refer to Section 5 *Words and phrases used in this Certificate* to familiarize yourself with these terms and their associated meaning whenever consulting this Certificate and the *Your Benefits* document.

You can view the current version of this Certificate online at manulife.ca/secureserve.

1 How your coverage works

When you bought this coverage, we agreed to provide you with benefits according to the terms of this Certificate if you pay your premiums.

Dental coverage pays for eligible expenses that are incurred for dental procedures performed by a licensed dentist, denturist, dental hygienist, and anaesthetist.

For each dental procedure, we only cover usual, reasonable, and customary charges. We do not cover more than the fee stated in the *Dental Association Fee Guide* for general practitioners in the province or territory where you live, regardless of where the treatment is received. Payments are based on the current guide at the time of treatment.

When a fee guide is not published for a given year, the term fee guide may also mean an adjusted fee guide established by us.

For services of a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that specialty, the fee guide approved by the provincial Dental Association for that specialist is used. Whenever one of the covered services requires in-office commercial laboratory services or study models, these fees are included.

Your Benefits

Your Benefits is a separate document issued to you accompanying this Certificate outlining the maximum coverage amounts for which you have been approved, along with any applicable provisions, and forms part of this Certificate. You can also visit *Your Benefits* on manulife.ca/secureserve.

Eligibility

To be eligible for insurance under the Group Policy, you must be:

- A Canadian resident who has submitted the application in a province or territory other than Quebec, and not a resident of Quebec at the time the application is submitted after the Group Policy has come into force,
- Covered under your provincial or territorial government health insurance plan,
- A member in good standing of an eligible association, who is under the age of 79 on the date of becoming insured under the Group Policy,

Or

- An employee of a member, regularly scheduled to work in the member's office at least 20 hours per week, and under the age of 70 on the date of becoming insured under the Group Policy.

A member or an employee may apply to insure their spouse or dependent child who may subsequently become insured as an independent person.

Dependent's eligibility

To be eligible for coverage under this Certificate, your dependent must be your spouse and/or your child, a resident of Canada and covered under the provincial or territorial government health insurance plan where you live.

If we decide that you or anyone else on the Certificate are not eligible, we may cancel the entire Certificate, cancel the coverage of the ineligible individual, or we may modify it. Premiums paid after cancellation will be returned for cancelled coverage.

Premiums

The premium, also known as the cost of insurance, is the amount we charge you to maintain this insurance and is shown on your *Summary of Information*. The cost of insurance is based on rates agreed to by us and the OMA. The *Summary of Information* shows your cost, including any applicable taxes.

The premium rate is subject to change if you change your coverage selection or if the coverage you chose has rate change on a scheduled renewal date. We'll send you a notice when your premium is scheduled to change. We reserve the right to change premiums required for this Certificate. If we do, we'll give you 30 days' notice.

The first premium payment is due at the time of your initial insurance application and covers you from your start date until your next premium due date. If we do not receive the first premium, or if the first premium is not honoured when first presented for payment, the insurance will not go into effect.

You can pay your premiums automatically from your bank account or credit card. Payments must be in Canadian dollars. Your insurance remains active from month to month if the required premiums are paid when due. You may request to change the premium payment frequency.

Grace period

If you don't pay your premiums, you have a 31-day grace period to pay the overdue amount to maintain your coverage. Your coverage remains active during this grace period. Your insurance ends on the last day of the grace period if we don't receive your full payment.

Claims

We pay for eligible expenses as described in the following sections, subject to any co-insurance or overall plan maximums shown in the *Your Benefits* document issued to the insured person. You may also review your plan details at manulife.ca/secureserve.

All references to **calendar year** means 12 months in a row starting on January 1 and ending December 31.

We must receive the claim form no later than 180 days after the earlier of:

- The end of the calendar year during which the expense occurred
- The end of your coverage

An eligible expense occurs on the date it is performed for a single procedure. If it takes more than one appointment, the expense occurs once the entire procedure is completed.

We'll pay for eligible expenses by direct deposit or cheque to you or a service provider within 15 days. If you die, we pay the claims to your estate.

If an insured person has eligible expenses for care, services, or supplies as described in this Certificate, or a sickness, injury, or other loss for which benefits are payable, we process and pay claims as follows:

- According to what is usual, reasonable, and customary, as determined by us
- That are within the maximums of your Certificate and *Your Benefits*
- That are medically necessary
- That, in the case of prescription drugs, are prescribed by a physician, nurse practitioner, dentist, denturist, or other licensed health care professional who has the authority to prescribe them
- That are payable according to law

We may require medical records or reports, proof of payment, itemized bills, or other information to assess a claim. Proof of claim is at your expense.

If your provider did not process your claims for expenses, you must submit those claims yourself.

Alternate procedures

We reserve the right to consider alternative procedures, services, courses of treatment, and materials, and to provide benefits based on the least costly 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.

Temporary services

If an insured person receives any temporary dental service, we consider it to be part of the final dental procedure used to correct the problem and not a separate procedure. The fee for the permanent service is used to determine the usual and reasonable charge for the final dental service.

Predetermination

If charges for any care, services or supplies are expected to exceed $500, we recommend that a detailed treatment plan be submitted before expenses are incurred. We will not determine the appropriateness of the treatment, but will advise the benefit payable, if any.

Coordination of benefits

You must send claims for reimbursement to any government plans first. If an insured person is eligible for similar benefits under another individual or other group plan, such as credit card coverage, auto insurance, private insurance, workers' compensation, etc., you may coordinate benefits between this Certificate and those plans.

For coverage under more than one plan, benefits are coordinated with other plans following insurance industry standards so that benefits payable from all plans do not exceed 100% of actual expenses. If your other plan doesn't allow coordination of benefits, you must submit a claim to that plan first. If the other plan does allow co-ordination of benefits, we prorate expenses among the plans, proportionate to the amounts that would have been paid if there was only one plan.

Insurance industry standards determine where a claim should be sent first. Here are some guidelines:

- If you're claiming expenses for your spouse and your spouse is covered for those expenses under another plan, the claim must be sent to your spouse's plan first.
- If you're claiming expenses for your dependent children and your spouse has coverage under a different plan, expenses must be claimed under the plan of the parent with the earlier birthday (month and day) in the calendar year.

The maximum amount that can be received from all plans for eligible expenses is 100% of actual expenses.

When your coverage begins

Your coverage starts on the effective date shown on the *Summary of Information.*

When your coverage ends

Your insurance coverage ends on the earliest of the following:

- The date the Group Policy ends
- The date you are no longer: a member in good standing of an eligible association or an employee, as applicable
- The date you no longer reside in Canada
- The date you are no longer covered under a provincial or territorial government health insurance plan
- The date we receive your written request to cancel your coverage
- The end of the grace period if you fail to pay your premium
- The date you die

Spouse's and Dependent Child's coverage ends on the earliest of the following dates:

- The date the Group Policy ends
- For a dependent child, the end of the last qualifying policy year on August 31st in which they are no longer a dependent child unless within 60 days of that date, they become insured as an independent person as provided under the continuation of dependent child or spousal coverage provision
- For a spouse, the date the spouse is no longer an eligible dependent
- The date the dependent no longer resides in Canada
- The end of the grace period if the premium is not paid, provided that the survivor benefit premium waiver is not in effect
- The date that you send us a written request to end the dependent's insurance
- The date the dependent is no longer covered under a provincial or territorial government health insurance plan
- Twelve (12) months following the date of your death. However, your spouse is eligible to apply for coverage as an independent person in accordance with the continuation of dependent child or spouse coverage provision

How to change or continue your coverage

As your life changes, your coverage can change with you. You can add or remove your spouse or a dependent child from your Certificate by notifying us online or in writing. We'll provide you with a revised *Summary of Information* to show the change to your Certificate and your new premium payment.

Change part of your coverage or cancel

If you choose to change or end your coverage, you can notify us online at manulife.ca/secureserve or call our customer service centre at 1-888-596-8881.

Continuation of dependent child or spouse coverage

A dependent child or spouse may apply to replace their insurance with coverage as an independent person if:

- The dependent child no longer satisfies the required definition for eligibility
- The spouse is widowed due to your death

Written request for independent person coverage must be made to us within 12 months from the end of the month in which dependent child or spousal coverage ends.

If the request is received by us:

- Within 60 days of the end of the month in which the dependent's coverage ends, coverage for an independent person begins on the first of the month following the date the dependent's coverage ends.
- After the 60th day and within 12 months of the end of the month in which the dependent's coverage ends, coverage for an independent person begins on the first day of the month coincident with or next following the date coverage is approved.

Reapplying for dental coverage

If your coverage under the Group Policy ends because premium payments aren't made or you cancel your dental coverage, you must wait for 24 months before we will consider another application for dental coverage.

The requirement doesn't apply to any dependent child or spouse who makes a written application to replace their insurance with insurance coverage as an independent person as provided under the continuation of dependent child or spousal coverage provision.

How to contact us

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

You can also send documents to:

Manulife, Individual Insurance
P.O. Box 17001, Station Waterloo
Waterloo, ON N2J 0G5
Attention: Policy Services

Call us at: 1-888-596-8881

2 Dental plan

Dental coverage pays for eligible expenses that are incurred for dental procedures performed by a licensed dentist, denturist, dental hygienist, and anaesthetist.

Preventive dental procedures

Subject to the exclusions in this section and the *Your Benefits* document, the following procedures are considered covered expenses up to the stated fee guide.

- Oral examinations: complete, recall and emergency or specific diagnostic
- X-rays: Complete, panorex, bitewing, and diagnostic
- Other services:
  - Required consultations between two dentists
  - Scaling and polishing and topical fluoride treatment once every 9 months
  - Emergency or palliative services
  - Diagnostic tests and laboratory examinations
  - Removal of impacted teeth and related anaesthesia
  - Oral hygiene instruction once per lifetime limit
  - Dependent children aged 18 and under:
    - Provision of space maintainers for missing primary teeth
    - Pit and fissure sealants

Basic dental procedures

Subject to the exclusions in this section and the *Your Benefits* document, the following procedures are considered covered expenses up to the stated fee guide.

- Fillings: silicate, acrylic, composite, or amalgam for teeth 1 – 6 only; amalgam for other teeth
- Extraction of teeth: removal of teeth, except removal of impacted teeth
- Restorative:
  - Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns
  - Dependent children aged 18 and under: stainless steel crowns or bands
- Removable prosthodontics: repairs, adjustments, relines, rebasing of dentures
- Endodontics: root canal therapy and root canal fillings, and treatment of disease of the pulp tissue
- Periodontics:
  - Treatment of disease of the gum and other supporting tissue
  - For scaling and root planing
- Oral surgery: surgery and related anaesthesia, other than the removal of impacted teeth

Exclusions

The following are not eligible expenses under this plan:

- Services or supplies payable or available (regardless of any waiting list) under any government–sponsored plan or program unless explicitly listed as a covered benefit
- Services or supplies that are not usually provided to treat a dental problem
- Procedures performed primarily to improve appearance
- The replacement of lost, misplaced or stolen dental appliances

- Charges for missed appointments
- Charges for completing claim forms
- Services or supplies for which no charge would have been made in the absence of this coverage
- Services usually intended for sport or home use, for example mouthguards
- Procedures or supplies used in full mouth reconstruction (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support)
- Transplants and repositioning of the jaw
- Experimental treatments
- Charges related to implants, including surgery charges except as indicated under the Group Policy

We will not pay for dental work resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- Teeth malformed at birth or during development
- Participation in a criminal offence

Survivor benefit

If youdie, coverage for your spouse and dependent children continues without premium payments until the earliest of the following:

- upon termination of the Group Policy, or
- upon completion of 12 months from the date of your death.

Your spouse has 60 days after the last day of the 12th month following your date of death, to apply for coverage as an independent person under the Group Policy, on a premium-paying basis, for themselves and any insured dependent children.

Payments after coverage ends

If your insurance is terminated, covered expenses that happen after the date of termination are not eligible, even if a treatment plan had been filed and we gave written authorization.

Exception:

If these covered dental expenses are performed within 31 days of the end of your coverage, and they were defined as a covered expense under this Certificate, then you can file a claim for these reasons.

- Dental restoration is in connection with crowns or bridges for which the tooth was prepared prior to the termination date
- A root canal therapy where the pulp chamber was opened prior to the termination of insurance

3 Dental Plus plan

Dental coverage pays for eligible expenses that are incurred for dental procedures performed by a licensed Dentist, denturist, dental hygienist, and anaesthetist.

Preventive dental procedures

Subject to the exclusions in this section and the *Your Benefits* document, the following procedures are considered covered expenses up to the stated fee guide.

- Oral examinations: complete, recall and emergency or specific diagnostic
- X-rays: complete, panorex, bitewing, and diagnostic
- Other services
  - Required consultations between two dentists
  - Scaling and polishing and topical fluoride treatment once every 6 months
  - Emergency or palliative services
  - Diagnostic tests and laboratory examinations
  - Removal of impacted teeth and related anaesthesia
  - Oral hygiene instruction
  - Dependent children aged 18 and under:
    - Provision of space maintainers for missing primary teeth
    - Pit and fissure sealants

Basic dental procedures

Subject to the exclusions in this section and the *Your Benefits* document, the following procedures are considered covered expenses up to the stated fee guide.

- Fillings: silicate, acrylic, composite, or amalgam for teeth 1 – 6 only; amalgam for other teeth
- Extraction of teeth: removal of teeth, except removal of impacted teeth
- Restorative:
  - Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns
  - Dependent children aged 18 and under: stainless steel crowns or bands
- Removable prosthodontics: repairs, adjustments, relines, rebasing of dentures once every 12 months
- Endodontics: root canal therapy and root canal fillings, and treatment of disease of the pulp tissue
- Periodontics:
  - Treatment of disease of the gum and other supporting tissue
- For scaling and root planing
- Oral surgery: surgery and related anaesthesia, other than the removal of impacted teeth

Major dental procedures

Subject to the exclusions in this section, the following procedures are considered covered expenses up to the stated fee guide.

Major restorations

- Inlays and onlays
- Crowns and repairs to crowns, other than prefabricated metal restorations
- Repair of bridges

For an implant related crown or prosthesis, we pay the benefit that would have been payable under the Group Policy for a tooth supported crown or non-implant related prosthesis respectively. We consider any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges are not covered.

Prosthodontics

- Construction and insertion of bridges or standard dentures. Coverage is limited to teeth extracted while the insured person is covered under the Group Policy. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5-year period following the construction or insertion of a previous bridge or standard denture unless it's needed to replace a:
  - Bridge or standard denture which has caused temporomandibular joint disturbances, and can't be economically modified to correct the condition
  - Transitional denture which was inserted shortly following extraction of teeth, and which can't be economically modified to the final shape required

Orthodontic procedures – 1 year waiting period

The following orthodontic procedures are covered, for dependent children aged 18 years and under only:

- Orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces
- Interceptive, interventive or preventive orthodontic services, other than space maintainers
- Comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment, and retention

Exclusions

The following are not eligible expenses under this plan:

- Services or supplies payable or available (regardless of any waiting list) under any government–sponsored plan or program unless explicitly listed as a covered benefit
- Services or supplies that are not usually provided to treat a dental problem
- Procedures performed primarily to improve appearance
- The replacement of lost, misplaced or stolen dental appliances
- Charges for missed appointments
- Charges for completing claim forms
- Services or supplies for which no charge would have been made in the absence of this coverage
- Services usually intended for sport or home use, for example mouthguards
- Procedures or supplies used in full mouth reconstruction (capping all the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support)
- Transplants and repositioning of the jaw
- Experimental treatments

We will not pay for dental work resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- Teeth malformed at birth or during development
- Participation in a criminal offence

Survivor benefit

If you die, coverage for your spouse and dependent children continues without premium payments until the earliest of the following:

- upon termination of the Group Policy, or
- upon completion of 12 months from the date of your death.

Your spouse has 60 days after the last day of the 12th month following your date of death, to apply for coverage as an independent person under the Group Policy, on a premium-paying basis, for themselves and any insured dependent children.

Payments after coverage ends

If an insured person's coverage ends, they are still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while they were covered, and the procedure is performed within 6 months after the date of the accident.

Covered expenses that happen after the date of termination are not eligible, even if a treatment plan had been filed and we gave written authorization.

Exception:

If the following covered dental expenses are performed within 31 days of the end of an insured person's coverage, and they were defined as a covered expense under this Certificate, then you can file a claim for these reasons:

- Dental restoration is in connection with crowns or bridges for which the tooth was prepared prior to the termination date
- It is root canal therapy where the pulp chamber was opened prior to the termination of insurance

4 General provisions

Entire contract

This Certificate, together with the *Summary of Information, Your Benefits*, applications for insurance submitted by you, and any schedules, riders, attachments, amendments and/or endorsements to this Certificate executed by us, constitutes the entire contract between the parties.

This Certificate is subject in all respects to the terms and conditions of the Group Policy. If there is any conflict between the terms and conditions of this Certificate and the Group Policy, the terms of the Group Policy take precedence to the extent permitted by applicable law. The Certificate will govern any matter requiring determination. It supersedes any previously issued Certificate.

Summary of Information

The *Summary of Information* is a separate document issued to you accompanying this Certificate outlining the benefits for which you have been approved, along with any applicable provisions, and forms part of this Certificate.

Benefits

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

Currency

All payments by us or to us under this Certificate must be in Canadian dollars.

Facility of payment

If for any reason, you are not competent to give a valid release for payments to which you are entitled, we may, at our discretion, make payment, to the extent permitted by law, to any person related to you, or to any other individual appearing to us to be equitably entitled to such payment. Any payment made by us in good faith pursuant to this provision fully discharges us to the extent of such payment.

Non-waiver

If we waive our rights in a specific instance or fail to insist on performance of any of the provisions of this certificate, that will not be construed as a subsequent waiver of the performance of, or any subsequent breach of, the same provision.

Governing law

This Certificate will be subject to the laws of the Canadian province or territory in which you resided at the time of application for insurance.

Provincial variations

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

Non-participating

This Certificate is non-participating and is not eligible to share in our divisible surplus. It has no cash value and receives no dividends.

Assignment

The insurance coverage evidenced by this Certificate may not be assigned.

Limitation of action

No legal action may be taken on claims until 60 days after due proof of claim has been submitted.

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 *Limitations Act, 2002*, in Ontario, if applicable, or such other applicable legislation of your province or territory.

Requesting copies of documents

Upon request and on reasonable notice, you may, at any time, obtain copies of:

- your application for insurance
- any written statements or other record, not otherwise part of the application for insurance, that you have provided to us as evidence of insurability
- the Group Policy

The first copy will be provided at no cost, but a fee may be charged for subsequent copies. All requests for copies of documents should be directed to us.

Clerical error

Clerical error by the OMA or by us in administering this certificate will not:

- Invalidate coverage that is otherwise in force
- Render insurance valid which would, but for such error, not validly be in force, or
- Continue coverage otherwise validly terminated

We or the OMA will not refund premiums for any period which is more than 12 months prior to the date we or the OMA receive proof in writing of your right to a refund.

Changes and amendments

We may at any time, by agreement with the OMA, amend the provisions of this Certificate. You will be provided with written notification of any changes to this Certificate. Your consent is not required. No such amendment will in any way affect our liability in respect of any loss that occurs prior to the start date of the amendment.

We may also change the benefits, terms, and conditions of this Certificate at any time, in response to changes in provincial, territorial, or federal legislation, or regulations retroactive to the date of such changes.

Misstatement of age

If due to the misstatement of your age or the age of any of your eligible family members:

- we would not have issued the insurance coverage because the true age at issue does not meet the eligibility requirements in effect when the coverage was issued, then we may declare the insurance void and our liability will be limited to the refund of all premiums paid for the coverage.
- the coverage has been in effect longer than it would have been based on the true age at issue, we will terminate the coverage effective on the date the coverage would have ceased according to the

true age and, if we accepted a premium for a period beyond that date, our liability will be limited to the refund of all premiums paid for the period during which coverage would not have been in effect.

Otherwise, if the amount of insurance for any insured person in accordance with the terms and conditions of this Certificate has been affected by a misstatement of age, the amount of insurance will be adjusted to the amount to which an insured person would have been entitled as determined using the true age, and an equitable premium adjustment will be made.

If the amount of premium applicable to you has been affected by such misstatement of age, the amount of premium applicable to you will be adjusted to the amount determined by the true age, and an equitable premium adjustment will be made.

We may request proof of age for any person insured under this Certificate. If a date of birth is misstated, it will be corrected, and the following may occur:

- Rates may be adjusted
- The date coverage starts may change
- The amount and type of coverage may be reduced or cancelled, and/or
- Any rights or benefits provided under this Certificate may be changed

Misrepresentation, adjustments, and incontestability

Any failure to disclose or misrepresentation of a fact material to the insurance could render your insurance voidable by us.

Where there are multiple people insured under the Certificate, we may either cancel the entire Certificate, modify, or cancel only the coverage of the individuals insured to whom the failure to disclose relates.

In addition, we have the right to subtract any claims we've paid from any premiums we refund. However, after coverage has been in force for a period of 2 years, we can't cancel any coverage, unless a fraud is committed.

5 Words and phrases used in this Certificate

accident/accidental – is bodily injury sustained by an insured person, occurring while this insurance is in-force, and resulting solely and directly from unforeseen accidental, outward, and visible means, and which independently of all else causes the death or dismemberment or injury within 365 days after the accidental injury was sustained.

age – is an insured person's actual age in completed years on the start date of the coverage and on each subsequent Certificate calendar year.

application date – the date we receive the application for insurance at our office.

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

Certificate – is the certificate of insurance issued by us to you as evidence that we have granted you insurance under the Group Policy.

claim – eligible expenses for an illness or injury while this Certificate is active, or the act of telling us that an insured person has expenses, and you request payment.

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

co-insurance – the percentage of charges for eligible expenses that we pay.

cate expenses are incurred – the date the care, services or supplies are provided or purchased.

dentist, denturist – a practitioner 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 child – is the unmarried child, legally adopted child, or stepchild of either you or your:

- legally married spouse, who may or may not reside with you or your legally married spouse, but is fully dependent on you and your legally married spouse for support; or
- common-law spouse, who is in the care and custody of you and your common-law spouse, residing with you and your common-law spouse, and being fully dependent on you and your common-law spouse for support; and
- whose age is either less than 18; less than 25 if in full-time attendance at an accredited institution of learning, or any age if physically or mentally infirm and remains fully dependent on you or your spouse for support.

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

eligible association – is, with respect to its own members, the OMA, the New Brunswick Medical Society, the Medical Society of Prince Edward Island, and the Newfoundland and Labrador Medical Association.

eligible expenses – expenses for medically necessary services or supplies for the treatment of an illness or injury covered by this plan, according to the provisions, terms, limitations, and exclusions of the Certificate. Claimed expenses cannot exceed the usual, reasonable, and customary charges for the service or supply.

eligible family member – your spouse or dependent child as defined in this certificate, who are insured under family coverage.

emergency – an acute, unexpected, or unforeseen illness or accidental injury requires immediate, medically necessary treatment prescribed by a physician.

emergency services – any reasonable medical services or supplies, including advice, treatment, medical procedures, or surgery, required because of an emergency. When an insured person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the insured person leaving their province or territory of residence.

experimental** or **investigational treatment – a service, drug, treatment, or medical device that isn't approved by Health Canada for use in Canada or that isn't considered appropriate or acceptable by the medical profession in Canada.

employee – a permanent employee of a member who meets the eligibility requirements.

family coverage – your benefits cover a maximum of 2 adults aged 18 and older, and eligible children listed on the application form.

government health insurance plan – any plan or arrangement provided by or under the administrative supervision of any Canadian government agency 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.

Group Policy – is group policy #17884 issued by us to the OMA, and any associated amendments made to it.

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

immediate family member – the spouse, children (natural, adopted or step-relations), parents, siblings, grandparents, grandchildren, or in-laws of an insured person.

independent person – a resident of Canada, who is 18 years of age or older and is:

- either a dependent child of an insured member or an insured employee whose coverage as a dependent child terminates due to not meeting the requirements for dependent child,
- or the spouse of an insured member or an insured employee whose coverage as a spouse ends due to the death of the insured member or the insured employee.

illness – bodily injury, sickness, or disease.

injury – is an unforeseen accidental bodily injury caused by an accident that occurs while your insurance is in force, which injury is the basis of claim, resulting directly and independently of all other causes of loss covered by the certificate, and that is not caused or contributed to, directly or indirectly, by illness or disease, or treatment for such illness or disease.

insured** or **insured person – means you your spouse and/or each dependent child who is eligible for insurance under the Group Policy and for whom such coverage is in effect.

insured employee – an employee whose application for insurance has been accepted and is in force under the Group Policy.

insured independent person – an independent person whose application for insurance has been accepted and is in force under the Group Policy.

insured member – a member whose application for insurance has been accepted and is in force under the Group Policy.

insurer – is 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.

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

medically necessary – care, services, or supplies an insured person receives from a physician, nurse practitioner, or health care professional that we consider:

- Appropriate and consistent with the symptoms, findings, diagnosis, and treatment of the insured person's illness or injury,
- Generally accepted medical practice in Canada.

The fact that the insured person's physician or nurse practitioner prescribes the care, service, or supply doesn't automatically mean that it's medically necessary and covered by the Certificate.

member – a physician who meets the eligibility requirements under the Group Policy.

OMA – is the Ontario Medical Association.

out-of-pocket expenses – costs paid by or on behalf of an insured person which aren't covered or reimbursed under this Certificate.

physician – is a physician or surgeon who is licensed as such in Canada, and who is practicing within the scope of the physician's licensed authority. The treating physician may not be you or an immediate family member, or anyone who resides with you.

qualified – a person who is a member of the appropriate governing body established by the provincial government for their profession. If there is no governing body, the person must be an active member of an association approved by us.

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

spouse – is your spouse by marriage or under any other formal union recognized by law, or a person of the opposite sex or same sex who is publicly represented as your spouse and who resides in Canada. You can only cover one spouse at a time.

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 care medically required for the condition, symptom, or problem.

usual, reasonable, *and* ***customary*** – in relation to charges, means the lowest of:

- The prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by us
- The amount shown in the applicable professional association fee guide
- The maximum price established by law

we, our, *or* ***us*** – is The Manufacturers Life Insurance Company (Manulife).

you, *and* ***your*** – means either the insured member, insured employee, or the insured independent person, as applicable, who is the person named on the *Summary of Information.*

Underwritten by The Manufacturers Life Insurance Company (Manulife)