Manulife

Certificate of Insurance
OMA Priority Insurance Program (OPIP)
Group Extended Health Care – Health, Health Plus Rider and Health Care Spending Account (HCSA)

Benefits are administered and underwritten by:

The Manufacturers Life Insurance Company (Manulife)

We administer this Certificate #1777MP and pay benefits to the person named in the *Summary of Information*, according to the terms, conditions, and limitations of Group Policy #50131, 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 05G

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

Manulife

Table of Contents

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 space.

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 8 **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.

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 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,
- Licensed with the College of Physicians and Surgeons of Ontario to practice medicine in Ontario,
- Actively engaged in providing medical services in the province of Ontario for at least 15 hours per week on average and is remunerated by the Ministry through OHIP or by an employer for providing insured clinical services,
- A member in good standing of the OMA or, if not a member, has paid any OMA dues and assessments owing under the Ontario Medical Association Dues Act, 1991,
- Not a medical resident,
- Insurable under a contract of insurance for the program; and
- Covered under your provincial or territorial government health insurance plan.

Dependent's eligibility – Health & Health Plus Rider

To be eligible for coverage under the Heath & Health Plus Rider, 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.

Dependent's eligibility – Health Care Spending Account (HCSA)

For the HCSA only, a dependent may be your spouse, your children, or any other person whom you may claim as dependents under the *Income Tax Act* (Canada). For example, this could include members of your extended family, such as your parents, grandparents, or grandchildren. For the HCSA, you can claim eligible expenses for dependents even if they are not covered under your OPIP plan.

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.

Government-subsidized premium

If you are eligible for the government-subsidized Physician Health Benefit Program (PHBP), your premium cost is subsidized by the Ministry of Health and Long-Term Care through Ontario Physicians Services Inc., with the remainder paid by you. The subsidy amount is not guaranteed and is subject to change. To continue to qualify for this subsidy, at each renewal you must be residing in a province or territory in Canada, other than in Quebec, and you must meet the above eligibility requirements, except that you do not become ineligible if you are absent from practice due to disability or parental leave of up to 18 months. If you do not return to practice after the disability or parental leave ends, you may elect to continue your coverage at your own expense.

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

Claim forms can be found online at manulife.ca/secureserve. 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.

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.

Health and Health Plus Rider: You can claim eligible expenses in the current calendar year, and up to the end of 180 days of the following year, or up to 180 days after the insured person's coverage ends.

Health Care Spending Account: You can claim eligible expenses in the current calendar year, and up to the end of 90 days of the following year, or up to 90 days after the insured person's coverage ends.

Coordination of benefits

You must send your 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 the other plan doesn't allow coordination of benefits, you must submit a claim to that plan first. If your other plan does allow co-ordination of benefits, we prorate expenses among the plans, proportionate to the amounts that would have been paid if there was only one plan.

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

Proof of good health

Proof of good health for the extended health care coverage is required with the following exceptions:

- During specified open enrolment periods as agreed to in writing by us and the OMA
- For changes to extended health care coverage within 90 days of you having an eligible life event change

- For any dependent child or spouse who requests coverage as an independent person under Group Policy #17884 within 60 days of the end of the month after their dependent coverage ends under the Group Policy.

When your coverage begins

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

A dependent's insurance begins on the later of the following dates.

- The date your own coverage starts
- The date a dependent is eligible for benefits, and the application is made within 90 days of their eligibility, or you have an eligible life event change
- On the date the coverage is approved by us, if proof of good health is required

When your coverage ends

Your insurance coverage ends on the earliest of the following dates.

- The Group Policy ends
- The end of the last day of the month that you are no longer eligible for insurance under the Group Policy, unless any of the following apply.
    - You apply for continuation of insurance, if applicable
    - You are receiving disability benefits under the Canada Pension Plan or any other plan which provides total, partial or residual disability benefit payments
    - You are on an 18-month parental leave period
- 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

Dependents

Your dependent's insurance ends on the earliest of the following dates:

- The Group Policy ends
- The Group Policy no longer permits coverage for dependents
- A spouse or a dependent child:
    - Is no longer an eligible dependent
    - No longer resides in Canada
    - 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 under the Group Policy #17884
- The end of the grace period
- The date that you send us a written request to end the dependents insurance

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 dependents 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 coverage 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.

OPIP Continuance

When your insurance ends because you no longer meet the insurance eligibility requirements set out in this Certificate, you may continue your insurance, on a full premium paying basis. To be eligible to continue your insurance, you must have been covered for at least 12 consecutive months under the Group Policy.

Within 60 days after the last day you were eligible for insurance under the Group Policy, you must notify us to request for continuation of insurance.

This continuation of insurance provision is subject to the provisions of the Group Policy.

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 Extended Health Care – Health plan

This section outlines certain terms applicable to the benefits available to you, and all dependents covered for extended health care coverage.

The insured person must be enrolled in a government health insurance plan. The health care benefits available under this Certificate are subject to the limitations, exclusions, and reductions of coverage which may appear in the description of each benefit. Lifetime maximums apply to some benefits.

Reference to physician may also include a nurse practitioner. If the applicable provincial or territorial legislation permits nurse practitioners to prescribe or order certain supplies or services, we will reimburse those eligible expenses in the same was as if they were prescribed or ordered by a physician.

We will pay for eligible expenses as described in this section, subject to any co-insurance or overall plan maximums shown in *Your Benefits*.

Prescription drugs

We will cover the cost of drugs and supplies if they are prescribed by a licensed practitioner and are obtained from a pharmacist. Eligible drugs covered under this plan must have a Drug Identification Number (DIN). The amount payable for prescription drug expenses is subject to any drug deductible, any drug dispensing fee maximum, the co-insurance for drugs, and any maximum amount we set.

Eligible prescription drugs include:

- Drugs that legally require a prescription
- Life-sustaining drugs that may not legally require a prescription
- Injectable drugs and vitamins
- Compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN
- Diabetic supplies
- Assisted conception
- Vaccines
- Intrauterine devices (IUDs) and diaphragms
- Varicose vein injections

A single purchase is limited to quantities that can be reasonably used in a 34-day period, or up to 100 days for maintenance drugs, as ordered by a physician.

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a physician or dentist, if the applicable provincial or territorial legislation permits them to prescribe those drugs.

Drug substitution limits – Charges more than the lowest priced equivalent generic product are not covered unless the physician or dentist specifies in writing that no substitution for the prescribed drug may be made.

Prescription drug exclusions

Even when prescribed, the following drugs are not covered:

- Infant formulas (milk and milk substitutes), minerals, proteins
- Vitamins, and collagen treatments
- The cost of giving injections, serums, and vaccines
- Weight-loss treatments, including drugs, proteins and food or dietary supplements
- Hair growth stimulants

- Smoking cessation products
- Drugs for the treatment of sexual dysfunction
- Drugs used for cosmetic purposes
- Natural health products, including those with a Natural Product Number (NPN)
- Drugs, treatments, services, and supplies relating to the administration of the drug and treatment, administered in a hospital, as an in-patient or out-patient, or in a government-funded facility

Hospitalization

We will cover care in the province or territory in Canada where the insured lives, up to the maximums defined in *Your Benefits*, as follows:

- Hospital: the difference between a ward and a semi-private hospital room
- Convalescent hospital:
  - If ordered by a physician for rehabilitation, not custodial care
  - If the insured is admitted within 24 hours after being a hospital in-patient
  - The difference between the cost of a ward and the cost of a semi-private room
- Rehabilitation centre for addiction treatment or mental health disorders, for treatment in a government or non-government subsidized centre
  - The difference between a ward and a semi-private room or a ward and a private room

Ambulance services

Charges for licensed ambulance service or other emergency service when used to transport the insured person from:

- The place where the injury or illness occurs to the nearest hospital able to provide adequate treatment
- One hospital to another hospital
- A hospital to the insured person's residence

Nursing

To be eligible, services must include substantive elements of personal care, be certified as medically necessary, and be provided in the insured's primary residence in Canada. We're able to recommend qualified caregivers for homecare or nursing services. Requests for homecare or nursing services must include substantive elements of personal care, be made before the services begin to determine the type of caregiver and duration of eligible services and are subject to approval.

You must send us a Prior Authorization form, signed by a physician or nurse practitioner. We'll advise you of the approval for the type of caregiver and duration of eligible services. For urgent and immediate needs, contact our call centre at 1-888-596-8881.

We cover the costs for professional services of Registered Nurses (R.N.), Registered Nurses Assistants (R.N.A.) and Licensed Practical Nurses (L.P.N.), up to the maximums defined in *Your Benefits*.

Exclusions:

- Nursing services provided during confinement in a hospital
- Services which are primarily for custodial care and not rehabilitation
- Services provided by a person related to you
- Services provided or reasonably able to be provided by a person residing with you

Pregnancy and Family Support Benefits

We cover the costs for a lactation consultant and a birthing coach up to the maximum defined in *Your Benefits*. They must be licensed, certified, or registered in the insured's province or territory of residence and not someone related to or living with the insured. The services of a registered nurse are eligible only when someone with lesser qualifications can't perform the duties.

Medical services

We cover the costs for the medical services listed below, when ordered by a physician, or licensed professional. The services of a dentist, licensed optometrist, or ophthalmologist do not require a physician's order.

- Up to the combined maximum per insured person in a calendar year, as defined in *Your Benefits*, for these medical services:
  - Laboratory tests, ultrasounds and other medical imaging services excluding MRI (magnetic resonance imaging) and CT (computed tomography) scans performed outside of a hospital, except if the insured person's provincial or territorial government health insurance plan prohibits payment of these expenses
  - Oxygen, plasma, and blood transfusions
  - Radiotherapy or coagulotherapy
  - Artificial limbs and eyes
  - Colostomy and ileostomy supplies
  - Insulin pumps
  - Continuous glucose sensors and continuous glucose transmitters prescribed by a diabetologist or a specialist in internal medicine
  - Cosmetic surgery required because of an accident that occurs while coverage is in force. Treatment must be started within 12 months of the accident and completed within 36 months of the accident
- Pharmacogenomics prescribed by a physician to confirm an insured's compatibility with a specific drug for an established medical diagnosis
- Accidental dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while an insured person is covered. These services must be received within 3 years of the accident. We will not cover more than the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province or territory where the insured person lives. The guide must be the current guide at the time that treatment is received.
  If the coverage terminates and the accident occurred while the insured person was covered, and the procedure is performed within 6 months after the date of the accident, coverage continues for this incident.
- Wigs following chemotherapy. A physician's order isn't required
- Breast prostheses
- Surgical bras
- Stump socks
- Compression stockings, including pressure gradient hose
- Custom-made orthotic inserts for shoes, custom-made orthopaedic shoes, or modifications to orthopaedic shoes
- Glucometers

Medical equipment

We will cover, up to the maximum defined in *Your Benefits*, the cost of:

- Medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. For equipment to be eligible, we may require a physician's prescription. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the insured person's medical condition warrants the use of an electric wheelchair.
- Casts, splints, trusses, braces, or crutches.

Paramedical services

We cover the costs for qualified paramedical practitioners, up to the maximums defined in *Your Benefits*, as described in this section of the policy.

Qualified paramedical practitioners must:

- Belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us
- Be licensed or registered, as required by the applicable provincial or territorial regulatory body
- Have undergone appropriate training and obtained necessary credentials in support of the services or supplies provided
- Maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association
- Produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us
- Not engage in administrative practices unacceptable to us

This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide supplies. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified to provide services or supplies eligible for reimbursement under this plan.

Eligible paramedical services:

- Physiotherapist
- Massage therapists
- Naturopaths
- Doctor of Osteopathy and osteotherapists
- Acupuncturists
- Podiatrists or chiropodists
- Kinesiologists or kinotherapists
- Speech therapists
- Chiropractors
- Mental health support
    - Psychologist
    - Psychotherapist
    - Social worker
    - Clinical counsellor

Hearing aids

Charges for hearing devices must be processed through any applicable government programs first and then sent to us. Repairs and moulds are included as eligible expenses.

Exclusions:

- Medical examination, audiometric examination, or hearing evaluation tests
- The cost of batteries

Exclusions: Extended Health Care – Health

The following services or supplies are not eligible, regardless of any waiting list, under any government-sponsored plan or program unless explicitly listed as a covered benefit.

- Cosmetic surgery, except to the extent necessary to repair disfigurement due to and injury sustained while insured
- An exam by, or the services of, a physician or surgeon if required for the use of a third party
- Dental expenses, work or treatment on the teeth or gums, except as indicated elsewhere in this Certificate
- Any services or supplies that aren't usually provided to treat an illness, including experimental or investigational treatments
- Drugs available without a prescription
- Care, treatment, services or supplies not recommended and approved by a physician
- Vision care including glasses, contacts, and eye exams
- Any portion of eligible benefits that have already been paid by any applicable government health or drug insurance plan
- Services or supplies which would have been payable or available under any government-sponsored plan or program had proper application been made, unless explicitly covered under this benefit
- Expenses that aren't payable according to any exclusions, limitations, conditions, and amendments to this Certificate
- Prescription drugs, services, or supplies that aren't approved by Health Canada or another government regulatory body
- Services, supplies, or treatment that aren't generally recognized by the medical profession in Canada as appropriate, effective, or required for the treatment of an accident, injury, or illness in accordance with Canadian medical standards
- Services, supplies, devices, or items that don't qualify as medical expenses under the *Income Tax Act (Canada)*, unless covered under this Certificate, or
- Services or drugs administered in a hospital to in-patients and outpatients

We will not pay benefits when the claim is for an illness or injury resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- 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 #17884, on a premium-paying basis, for themselves and any insured dependent children.

3 Extended Health Care – Health Plus Rider

You can apply for the Health Plus Rider if you are approved for Extended Health Care – Health, under the Group Policy. Except as noted in this section, the Health Plus Rider is subject to all provisions, definitions, limitations, and conditions of the Group Policy.

This section outlines certain terms applicable to the benefits available to you, and all dependents covered for extended health care coverage.

The insured person must be enrolled in a government health insurance plan. The health care benefits available under this Certificate are subject to the limitations, exclusions, and reductions of coverage which may appear in the description of each benefit. Lifetime maximums apply to some benefits.

Reference to physician may also include a nurse practitioner. If the applicable provincial or territorial legislation permits nurse practitioners to prescribe or order certain supplies or services, we will reimburse those eligible expenses in the same was as if they were prescribed or ordered by a physician.

We will pay for eligible expenses as described in this section, subject to any co-insurance or overall plan maximums shown in *Your Benefits*.

Prescription drugs

We will cover the cost of drugs and supplies if they are prescribed by a licensed practitioner and are obtained from a pharmacist. Eligible drugs covered under this plan must have a Drug Identification Number (DIN). The amount payable for prescription drug expenses is subject to any drug deductible, any drug dispensing fee maximum, the co-insurance for drugs, and any maximum amount we set.

Eligible prescription drugs include:

- Drugs that legally require a prescription
- Life-sustaining drugs that may not legally require a prescription
- Injectable drugs and vitamins
- Compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN
- Diabetic supplies
- Assisted conception
- Vaccines
- Intrauterine devices (IUDs) and diaphragms
- Varicose vein injections

A single purchase is limited to quantities that can be reasonably used in a 34-day period, or up to 100 days for maintenance drugs, as ordered by a physician.

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a physician or dentist, if the applicable provincial or territorial legislation permits them to prescribe those drugs.

Drug substitution limits – Charges more than the lowest priced equivalent generic product are not covered unless the physician or dentist specifies in writing that no substitution for the prescribed drug may be made.

Prescription drug exclusions

Even when prescribed, the following drugs are not covered:

- Infant formulas (milk and milk substitutes), minerals, proteins
- Vitamins, and collagen treatments
- The cost of giving injections, serums, and vaccines

- Weight-loss treatments, including drugs, proteins and food or dietary supplements
- Hair growth stimulants
- Smoking cessation products
- Drugs for the treatment of sexual dysfunction
- Drugs used for cosmetic purposes
- Natural health products, including those with a Natural Product Number (NPN)
- Drugs, treatments, services, and supplies relating to the administration of the drug and treatment, administered in a hospital, as an in-patient or out-patient, or in a government-funded facility

Hospitalization

We will cover care in the province or territory where the insured lives for:

- Hospital: the difference between a ward and a semi-private hospital room
  - Up to the maximum defined in *Your Benefits*.
- Convalescent hospital:
  - If ordered by a physician for rehabilitation, not custodial care
  - If the insured are admitted within 24 hours after being a hospital in-patient
  - The difference between a ward and a semi-private room
  - Up to the maximum defined in *Your Benefits*
- Rehabilitation centre for addiction treatment or mental health disorders, for treatment in a government or non-government subsidized centre
  - The difference between a ward and a semi-private room or a ward and a private room
  - Up to the maximum defined in *Your Benefits*.

Ambulance services

Charges for licensed ambulance service or other emergency service when used to transport the insured person from:

- The place where the injury or illness occurs to the nearest hospital able to provide adequate treatment
- One hospital to another hospital
- A hospital to the insured person's residence

Nursing

To be eligible, services must include substantive elements of personal care, be certified as medically necessary, and be provided in the insured's primary residence in Canada. We're able to recommend qualified caregivers for homecare or nursing services. Requests for homecare or nursing services must include substantive elements of personal care, be made before the services begin to determine the type of caregiver and duration of eligible services and are subject to approval.

You must send us a Prior Authorization form, signed by a physician or nurse practitioner. We'll advise you of the approval for the type of caregiver and duration of eligible services. For urgent and immediate needs, contact our call centre at 1-888-596-8881.

We cover the costs for professional services of Registered Nurses (R.N.), Registered Nurses Assistants (R.N.A.) and Licensed Practical Nurses (L.P.N.), up to the maximums defined in *Your Benefits*.

Exclusions:

- Nursing services provided during confinement in a hospital

- Services which are primarily for custodial care and not rehabilitation
- Services provided by a person related to you
- Services provided or reasonably able to be provided by a person residing with you

Pregnancy and Family Support Benefits

We cover the costs for a lactation consultant and a birthing coach up to the maximum defined in *Your Benefits*, when medically necessary and ordered by a physician. They must be licensed, certified, or registered in the insured's province or territory of residence and not someone related to or living with the insured. The services of a registered nurse are eligible only when someone with lesser qualifications can't perform the duties.

Medical services

We cover the costs for the medical services listed below, when ordered by a physician, or licensed professional. The services of a dentist, licensed optometrist, or ophthalmologist do not require a physician's order.

- Up to the combined maximum per insured person in a calendar year, as defined in *Your Benefits*, for these medical services:
    - Laboratory tests, ultrasounds and other medical imaging services excluding MRI (magnetic resonance imaging) and CT (computed tomography) scans performed outside of a hospital, except if the insured person's provincial or territorial plan prohibits payment of these expenses
    - Oxygen, plasma, and blood transfusions
    - Radiotherapy or coagulotherapy
    - Artificial limbs and eyes
    - Colostomy and ileostomy supplies
    - Insulin pumps
    - Continuous glucose sensors and continuous glucose transmitters prescribed by a diabetologist or a specialist in internal medicine
    - Cosmetic surgery required because of an accident that occurs while coverage is in force. Treatment must be started within 12 months of the accident and completed within 36 months of the accident
- Pharmacogenomics prescribed by a physician to confirm an insured's compatibility with a specific drug for an established medical diagnosis
- Accidental dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while an insured person is covered. These services must be received within 3 years of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province or territory where the insured person lives. The guide must be the current guide at the time that treatment is received.
  If the coverage terminates and the accident occurred while the insured person was covered, and the procedure is performed within 6 months after the date of the accident, coverage continues for this incident.
- Contact lenses or intraocular lenses following cataract surgery
- Wigs following chemotherapy. A physician's order isn't required
- Breast prostheses
- Surgical bras
- Stump socks
- Compression stockings, including pressure gradient hose

- Custom-made orthotic inserts for shoes, custom-made orthopaedic shoes, or modifications to orthopaedic shoes
- Glucometers

Medical equipment

We will cover, up to the maximum defined in *Your Benefits*, the cost of:

- Medically necessary equipment rented, or purchased at our request, that meets the insured person's basic medical needs. For equipment to be eligible, we may require a physician's prescription. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the insured's person's basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the insured person's medical condition warrants the use of an electric wheelchair.
- Casts, splints, trusses, braces, or crutches.

Paramedical services

We cover the costs for qualified paramedical practitioners, up to the maximums defined in *Your Benefits*, as described in this section of the policy.

Qualified paramedical practitioners must:

- Belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us
- Be licensed or registered, as required by the applicable provincial or territorial regulatory body
- Have undergone appropriate training and obtained necessary credentials in support of the services or supplies provided
- Maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association
- Produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us
- Not engage in administrative practices unacceptable to us

This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide supplies. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified to provide services or supplies eligible for reimbursement under this plan.

Eligible paramedical services:

- Physiotherapist
- Massage therapists
- Naturopaths
- Doctor of Osteopathy and osteotherapists
- Acupuncturists
- Podiatrists or chiropodists
- Kinesiologists or kinotherapists
- Speech therapists
- Chiropractors
- Audiologists
- Occupational therapists
- Dieticians

- Mental health support:
  - Psychologist
  - Psychotherapist
  - Social worker
  - Clinical counsellor

Hearing aids

Charges for hearing devices must be processed through any applicable government programs first and then sent to us. Repairs and moulds are included as eligible expenses.

Exclusions:

- Medical examination, audiometric examination, or hearing evaluation tests
- The cost of batteries

Vision care

When prescribed by an ophthalmologist or licensed optometrist, eligible expenses include:

- Contact lenses or eyeglasses, purchased from an ophthalmologist, licensed optometrist, or optician
- Laser eye correction surgery, performed by an ophthalmologist
- Eye exams by an ophthalmologist or optometrist

Exclusions:

- Eyewear cleaning supplies and accessories
- Sunglasses, magnifying glasses, safety glasses, unless they are prescription glasses needed for correction of vision

Exclusions: Extended Health Care - Health Plus Rider

We will not pay for the following 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.

- Cosmetic surgery, except to the extent necessary to repair disfigurement due to and injury sustained while insured
- An exam by, or the services of, a physician or surgeon if required for the use of a third party
- Dental expenses, work or treatment on the teeth or gums, except as indicated elsewhere in this Certificate
- Any services or supplies that aren't usually provided to treat an illness, including experimental or investigational treatments
- Drugs available without a prescription
- Care, treatment, services or supplies not recommended and approved by a physician
- Any portion of eligible benefits that have already been paid by any applicable government health or drug insurance plan
- Services or supplies which would have been payable or available under any government-sponsored plan or program had proper application been made, unless explicitly covered under this benefit
- Expenses that aren't payable according to any exclusions, limitations, conditions, and amendments to this Certificate
- Prescription drugs, services, or supplies that aren't approved by Health Canada or another government regulatory body

- Services, supplies, or treatment that aren't generally recognized by the medical profession in Canada as appropriate, effective, or required for the treatment of an accident, injury, or illness in accordance with Canadian medical standards
- Services, supplies, devices, or items that don't qualify as medical expenses under the *Income Tax Act (Canada)*, unless covered under this Certificate, or
- Services or drugs administered in a hospital to in-patients and out-patients

We will not pay benefits when the claim is for an illness or injury resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- 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 #17884, on a premium-paying basis, for themselves and any insured dependent children.

4 Emergency medical travel assistance – Only available with the Health or Health Plus Rider

The emergency medical travel assistance is available to insured members to cover eligible expenses over and above those paid by their government health insurance plan. Please refer to *Your Benefits – Emergency Medical Travel Assistance and Referred Services*, which provides the details of your coverage.

5 Health Care Spending Account (HCSA)

General description of coverage

The OMA has the sole legal and financial liability for this benefit and funds the claims. We only act as administrator on behalf of the OMA.

Your HCSA reimburses you for services or supplies described in the *Your Benefits* document under Eligible expenses.

An expense occurs on the date the services are received, on the last date of multiple appointments for the same service, or the date supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to eligible expenses that occur after you become covered under the HCSA and before the date the HCSA ends.

To be sure your eligible expense meets the conditions necessary to qualify under the *Income Tax Act (Canada)*, you should visit the Canada Revenue Agency website for more details. Go to cra-arc.gc.ca and enter Medical Expense Tax Credits in the search window. Go to the most current version of publication #IT519 (Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction).

The calendar year is from January 1 through December 31.

How your HCSA works

Your HCSA works like an expense account. The OMA allocates plan credits to your account at the start of each calendar year.

Each time you submit an HCSA claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses described in the *Your Benefits* document under *Eligible expenses*, up to the balance of your HCSA. Expenses incurred in one calendar year can't be covered by credits received in the following calendar year.

Credits can only be used to provide reimbursement for eligible expenses. Eligible expenses are defined by the *Income Tax Act* (Canada). Examples of these expenses can be found in the *Your Benefits* document: "Eligible Expenses". Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the plan year following the plan year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

Benefit coverage from other plans

If you or your eligible dependents have coverage under another plan, send your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your HCSA.

When your HCSA benefit ends

Your coverage ends on the earliest of the following circumstances:

- When the Group Policy ends
- The end of the last day of the month you are no longer eligible for insurance under the Group Policy
- The date you are no longer a Canadian resident
- The date we receive your written request to cancel your coverage
- On the premium due date, if you fail to pay your premium, subject to the grace period
- The date you are no longer covered under a government insurance health plan
- The date you die

Making claims

Claim forms can be found online at manulife.ca/secureserve.

To receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the calendar year during which you incur the expense
- the end of your HCSA coverage

Please refer to *Your Benefits* – Health Care Spending Account for details about your coverage.

6 General provisions

Entire contract

This Certificate 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 and your dependents 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 policy 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.

7 Words and phrases used in this Certificate

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

active treatment hospital – an institution licensed as a hospital and operated for the care and treatment of resident 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. It doesn't include any hospital or institution or part of such hospital or institution licensed or used principally as a clinic, chronic care or extended care facility, convalescent home, rehabilitation centre, rest home, nursing home or home for the aged, health spa, or treatment centre for drug or alcohol abuse.

age – is yours or your spouse's or your dependent'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 you have expenses, and you request payment.

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

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

companion – any person who has prepaid accommodation and/or transportation with you for the same covered trip.

convalescent hospital – a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis, primarily for rehabilitation, and not custodial care. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

date 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 – your spouse or your child who is a resident of Canada. Your child must be your natural child, stepchild, or legally adopted child, who:

- is not married or in any other formal union recognized by law
- may or may not reside with you but is fully dependent on you for support
- is in your care and custody, residing with you and being fully dependent on you for support
- is under age 18, or under age 25 if a full-time student at an accredited institution of learning, or any age if physically or mentally disabled and remains fully dependent on you or your spouse for support.

drug – a medication that has been approved for use by Health Canada and has a drug identification number.

drug dispensing fee – the portion of the total prescription drug cost that is charged for the pharmacist's professional services for filling a prescription.

DIN – a number assigned by Health Canada to a drug product before it is marketed in Canada.

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

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 life event change – an event that gives you an opportunity to review and change benefit selection without providing evidence of good health if done so within 90 days of event:

- A marriage, separation, or divorce
- Dependent spouse or child becomes eligible for coverage
- The birth or adoption of a child
- Accepting legal guardianship of a child
- The loss or gain of extended health care insurance under your or your spouse's/partner's insurance
- Death of you, your spouse or dependent

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.

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 dependent 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 #50131 issued by us to the OMA, and any associated amendments made to it.

HCSA – *means* a Health Care Spending Account administered on behalf of the OMA, by us.

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

hospital – a public hospital licensed under the *Public Hospitals Act* or similar legislation of the province or territory in question or recognized by the Ministry of Health of the province or territory in question as a public hospital, or a duly licensed general active treatment hospital in another jurisdiction. Unless expressly stated otherwise in this Certificate, the term doesn't include a federal hospital, private hospital, rest home, nursing home, convalescent home, chronic care facility, health spa or hotel, and home for the aged.

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

immediate family member – the spouse, children (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 – sudden bodily harm caused by external and purely accidental means, independent of any sickness or disease.

in-patient – a person confined to a hospital for more than 24 consecutive hours.

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

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

insured employee – an employee 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, and
- 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.

nursing

- **nurse** – a person licensed or registered by the nursing regulatory body, college, or association in the province or territory where they work.
- **nurse practitioner (N.P.)** – a qualified registered nurse who has completed a graduate degree in nursing and is licensed in their region to:
    - Provide direct care to patients in the diagnosis and management of disease and illness,
    - Prescribe medications,

- Order and interpret laboratory tests,
- Initiate referrals to specialists, and
- Isn't the insured person or an immediate family member.

- **registered nurse (R.N.)** – a person who:
  - Holds a Certificate as a Registered Nurse (R.N.) under the *Health Disciplines Act* or similar legislation, or
  - Is registered or licensed in another area to provide services equivalent to those provided by an RN, and
  - Isn't a Registered Practical Nurse (R.P.N.), and
  - Isn't you or an immediate family member.
- **registered practical nurse (R.P.N.) or licensed practical nurse (L.P.N.)** – a person licensed, certified, or registered in the area where the services are provided, and who isn't you or an immediate family member.

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.

pharmacogenomics – the branch of genetics concerned with the way in which an individual's genetic attributes affect the likely response to therapeutic drugs.

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.

Physician Health Benefit Program (PHBP) – the OMA's benefits program underwritten by us under this Group Policy.

provincial plan – any plan which provides hospital, medical, drug, or dental benefits established by the government in the province or territory where the covered person lives.

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

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.

scans – images of internal structures of the body for the purpose of accurate diagnosis. Can also be an image or PDF of your application and any applicable medical forms.

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.

trip – any excursion taken by you outside your province of residence.

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

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

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

you *or* ***your*** – means the insured member who is the person named on the *Summary of Information.*

Underwritten by The Manufacturers Life Insurance Company (Manulife)