Canadian Benefits Plan

Plan Details

April 1, 2022- March 31, 2023

February 2022

Scotiabank®

How to use the Plan Details

The Plan Details explain the benefits offered by the Canadian Benefits Plan (the "Plan"). Learn what's covered under the Bank-paid Core Plan and decide which optional benefits and coverage levels are most appropriate for you and your eligible dependents.

Need help?

If you have any questions about the benefits offered or the coverage you've chosen, please call Manulife directly at 1-800-268-6195.

Representatives are available to answer questions:
Monday to Friday from 8 am to 8 pm Eastern Time (ET)

IMPORTANT – DISCLAIMER AND QUALIFICATIONS

This Plan Details booklet provides a summary of the benefits that make up the Canadian Benefits Plan (the "Plan") for eligible employees of The Bank of Nova Scotia ("Scotiabank" or the "Bank") the terms and conditions of which are governed by the official Plan documents (i.e. contracts and policies). This Plan Details booklet is intended for information only and not for advice. It does not confer any contractual rights or obligations. In the event of any inconsistency between this Plan Details booklet and the official Plan documents, the official Plan documents will govern. Unless otherwise defined in this Plan Details booklet, capitalized terms have the meaning set out in the official Plan documents.

Scotiabank reserves the right to amend or terminate all or any part(s) of the Plan at any time. Benefits coverage under the Plan is limited to a 12-month period each Plan year (April 1 to March 31). Any changes to Plan benefits will be communicated during the annual enrolment period and will take effect in the next Plan year.

If a government-sponsored program or plan or legally mandated program ends or reduces payment for any services, treatments or supplies, the Plan will not automatically cover these charges. The Bank reserves the right to decide, at the time of the change, whether the expenses will be considered eligible or not.

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What You Need to Know About the Canadian Benefits Plan

The Canadian Benefits Plan includes core coverage ("Core Coverage"), which is Bank-paid and employee-paid. It also includes optional coverage ("Optional Coverage") to meet your specific needs, some of which can be purchased using Bank-provided credits and some of which can be purchased through payroll deductions.*

What you should know

1 Core Coverage

Core Coverage includes Bank-paid and employee-paid coverage. Bank-paid Core Coverage includes Core Health coverage for you and your eligible dependents and Core Insurance for you (Short-term Disability and employee Life insurance). Core Health excludes Dental and Emergency Out-of-Province/Country Health insurance.

2 Credits

Credits can be used to buy Additional Personal Time, additional Health, Dental or Emergency Out-of-Province/Country Health insurance for you and your eligible dependents. If additional benefit costs exceed your credits, the rest can be paid for through payroll deductions. Any unused credits can be directed to the Health Care Spending Account, Wellbeing Account, or one of the group RRSPs (Scotia McLeod, Manulife or iTRADE).

3 Flexibility

You can choose the eligible dependents you would like to cover with Health, Dental and other benefits, including whether or not you would like to cover them under the Core Health Plan. The dependent coverage you select under Core Health will carry over into Optional Health if you elect to buy-up coverage. The dependents you choose to cover for Dental can be different than those you select to cover for Health.

4 Additional Optional Coverage

You can buy-up optional coverage for Life insurance, Accidental Death and Dismemberment and Critical Illness insurance for yourself and, if you choose, your eligible dependents. You may also buy-up optional coverage for Long-term Disability for yourself.

5 Provincial Health Care Coverage

Health Coverage, as well as Optional Emergency Out-of-Province/Country Health insurance coverage requires that you and your dependents also have provincial health care coverage in effect as coverage available in the Canadian Benefits Plan supplements, and does not replace, the available benefits under any government sponsored plan.

6 Opting Out

The Canadian Benefits Plan is designed to provide a core level of coverage for all employees. As such, employees cannot opt out. With a base level of coverage, you and your eligible dependents can focus on using Bank provided credits to better meet any additional needs you may have.

Effective dates of coverage

Each Plan year runs from April 1 to March 31.

When coverage begins

For you and your covered eligible dependents:

- Plan coverage begins on the first day of each Plan year if all eligibility requirements are met as of that day
- If you become eligible for the Plan after the start of the Plan year, your coverage begins on the date you become eligible
- If you make a change to your coverage due to a Work/Life Event, the change is effective on the day of the event

If you have to submit Evidence of Insurability (see page 7), your coverage begins on the day your application is approved.

When coverage ends

For you:

Plan coverage ends for you on the earliest of these events:

- Your employment ends due to resignation, frustration of contract and termination (whether for just cause or not)
- You no longer qualify as an eligible employee for the Plan, or
- The Plan ends

Each Plan year runs from April 1 to March 31.

For your covered eligible dependents:

If you have an eligible spouse and/or dependent children, the coverage for each dependent ends on the earliest of these events:

- The Plan ends
- Your own coverage ends (with the exception of Survivor Health and Dental Benefits), or
- Your dependent no longer meets the definition of an eligible dependent (see page 7)

*As a condition of employment, member contributions to benefits are made by way of payroll deductions.

Effective dates of coverage continued

Please see each benefit section for any additional specific start and end dates that may apply.

When you can change your coverage

Your benefit choices stay in effect for the duration of the Plan year. Once you make your choices and the enrolment window closes, you cannot change them until the following enrolment period, unless you experience a Work/Life Event during the year.

An example of a Work Event is a change in your employment status, e.g., from part-time to full-time. Examples of a Life Event include:

- Marriage
- Gaining or losing a dependent (e.g., the birth of a child, divorce or death of a spouse)
- Your spouse loses benefit coverage

If you experience a Work/Life Event, you have 31 days to update your benefits from the date of the event. Otherwise, you will need to wait until the next enrolment period. There are some Life Events, like adding a dependent child, where you can make the change directly on Manulife's site: me@scotiabank > *Pay and Benefits > My Benefits > Canadian Benefits Plan Member Site > My Benefits > Benefits Enroller > Manage My Plan.*

You may need to provide Evidence of Insurability for some coverage increases. See me@scotiabank > *Ask HR* for descriptions of Work/Life Events and their impact on benefits coverage.

Dental Option 3 cannot be decreased if you have not satisfied the two-full plan year lock-in period regardless if you experience a Work/Life Event or during annual re-enrolment.

How to pay for coverage

The Bank provides you with credits. You can use these credits to buy to buy Additional Personal Time, additional Health, Dental and Emergency Out-of-Province/Country Health insurance that best suit your needs. If the cost of these options exceeds your credits, you can use payroll deductions to pay for the difference.

You must use payroll deductions to buy additional Life, Long-term Disability, Accidental Death and Dismemberment or Critical Illness insurance.

Type of Coverage	Bank-Paid	Credits	Payroll Deductions (Employee Paid)
Additional Personal Time	X	✔	X
Health	✔ 50% paid	✔ Buy-up options	✔ Buy-up Options if no credits remain
TELUS Health Virtual Care	✔	X	X
Dental	X	✔ All options	✔ All options if no credits remain
Short-term Disability	✔	X	X
Long-term Disability	X	X	✔ All coverage (core and optional)
Life Insurance	✔ (1x Benefits Salary)	X	✔ All optional coverage
Accidental Death and Dismemberment Insurance	X	X	✔ All optional coverage
Emergency Out-of-Province/Country Health Insurance	X	✔	✔ If no credits remain
Critical Illness Insurance	X	X	✔ All optional coverage
Health Care Spending Account	X	✔	X
Wellbeing Programs and Services	✔	X	X
Wellbeing Account	X	✔	X
Group RRSP	X	✔	✔

Coordinating benefits with your spouse

Co-ordination of benefits lets you maximize reimbursement of eligible Health and Dental expenses, if you and your spouse are each covered as a dependent under the other's benefits plan.

If the claim is for…	First…	Then…
You	Submit the claim to Manulife.*	For any unpaid balance, send a copy of your Manulife Explanation of Benefits and the other insurance company's claim form to the other insurance company for processing.
Your spouse	Submit the claim to your spouse's insurance company.*	For any unpaid balance, send a copy of the other insurance company's Explanation of Benefits with a completed Manulife claim form to Manulife for processing.
Your dependent children	Submit the claim to the insurance company of the parent who has the earlier birth month and day.* (If both parents have the same birth month, then use the earliest day in the month.)	For any unpaid balance, send a copy of the Explanation of Benefits to the other insurance company.

*If you use the online claims submission, you will not have to send in your receipts but must keep them for at least one year as proof of your claims.

If you still have eligible expenses that you haven't been reimbursed for after submitting your claim to your spouse's plan, here's what to do.

If you have a Health Care Spending Account, submit another claim to Manulife, along with the Explanation of Benefits from your spouse's plan, and ask for the expenses to be paid from your Health Care Spending Account. If your spouse has an Health Care Spending Account, you can use it instead.

If the claim is for expenses for a covered dependent child, and the parents or legal guardians are separated or divorced, claims should be submitted in the following order:

- The plan of the parent or legal guardian who has custody of the dependent child
- The plan of the spouse of the parent or legal guardian who has custody of the dependent child, if applicable
- The plan of the parent or legal guardian who does not have custody of the dependent child.
- The plan of the spouse of the parent or legal guardian who does not have custody of the dependent child, if applicable

If the above rules do not apply, benefits will be prorated in proportion to the amount that would have been paid under each contract if that contract had been the only coverage in effect.

Eligibility

Employees

You are eligible for the Plan if you are:

- A regular full-time employee
- A regular part-time employee who is scheduled to work at least 7.5 hours per week, or
- A contract employee who
  - Has one year of continuous employment under the same employee number
  - Has a contract end date in the future, and
  - Is regularly scheduled to work at least 7.5 hours per week

Some benefits have additional eligibility rules. You'll find these in the relevant benefit section. For example, if you're a contract employee, you are not eligible for Long-term Disability or Survivor benefits.

Note

Any time worked as a co-op student, intern, work-placement, or contingent worker does not count towards satisfying the one year of continuous employment requirement.

Evidence of Insurability

Some benefit coverage levels are available only if you provide specific health information as Evidence of Insurability with your application. Each year when you enrol, the enrolment tool will show the benefits and coverage levels that require Evidence of Insurability. If Evidence of Insurability is required for the selected level of coverage, you can print Evidence of Insurability forms from the enrolment tool.

When re-enrolling, if you want to keep the same coverage as you had previously for Life or Critical Illness insurance, you will not need to provide Evidence of Insurability. If you choose to increase your coverage, for you or your spouse, you will need to provide Evidence of Insurability. In addition, if you decide to cancel existing coverage for you or your spouse, you will be required to provide Evidence of Insurability to begin coverage at a later date.

If a request for increased Life or Critical Illness insurance has been denied, you (or your spouse) will retain the existing level of coverage. Evidence of Insurability is not required for Accidental Death and Dismemberment, Child Life insurance or Child Critical Illness insurance. For Evidence of Insurability information on Long-term Disability insurance, please see page 26.

Eligible dependents

To be eligible for coverage, your dependents must meet the following definitions of spouse or dependent child.

Your spouse

You can include only one person at a time as your spouse. Your spouse is the person who:

- Is legally married to you, or
- Lives with you in a conjugal relationship for at least one year immediately preceding the date as of which a determination is required year (in Quebec this can be a shorter period if you have a natural or adopted child from the relationship).

Spouse does not include a divorced spouse for the purpose of employee benefits.

Eligible children

To be covered, your dependent child must be:

- A natural or adopted child, a step-child, a child of your common-law partner or a child for whom you're the legal guardian,
- Unmarried and not in any other formal union,
- Not employed full-time and not eligible for benefits as an employee under the Plan or any other group plan,
- Financially dependent on you and/or your spouse and eligible to be claimed as an exemption for income tax purposes,
- Under age 21, or, if registered as a full-time student at an accredited educational facility, under age 25 (under age 26 in Quebec).
- Children of any age are eligible if they are physically or mentally incapable of self-support and entirely dependent on you. The disability must have occurred prior to the child reaching the maximum age for coverage shown above.

To update information on your dependents:

To update spousal information, you will first need to update your marital status and effective date in your My Profile in me@scotiabank. Once complete, contact Ask HR to provide your spouse's name and date of birth.

Adding or changing information on your dependent children can be done directly on Manulife's site: me@scotiabank > *Pay and Benefits > My Benefits > Canadian Benefits Plan Member Site > My Benefits > Benefits Enroller > Manage My Plan*

Smoker status

Whether or not you or your spouse smokes will affect coverage under certain benefits.

If you're buying Optional Health coverage, smoker status is applied if either you or your spouse is a smoker. For Optional Life insurance for you or your spouse, the covered person is considered a non-smoker if they have not used any tobacco products for at least 12 consecutive months before you enrol in the plan.

For Critical Illness insurance for you or your spouse, the covered person is considered a non-smoker if they have not smoked any cigarettes, cigarillos, cigars, marijuana, betel nut, pipes or used chewing tobacco or any nicotine products (patch, gum etc.) within the past 12 months.

If you say you and/or your spouse are a non-smoker when you enrol in the Plan, and a claim is made for Life insurance or Critical Illness insurance, and it is determined that you and/or your spouse have smoked since enrolling (Optional coverage), benefits may not be paid to you or your beneficiaries.

If you start smoking

If you enrol yourself or your spouse in the plan as a non-smoker, and then start or resume smoking, you must tell Manulife about this change by calling them directly at 1-800-268-6195. Your premium rates will be adjusted accordingly.

Your Core Coverage

Bank-Paid Core Coverage includes:

1) Core Health Coverage is for you and the eligible dependents you choose to cover:

Coverage	Details
Annual out-of-pocket maximum	$6,000 for you and your eligible dependents combined for eligible Health claims
Dispensing fee cap	$8.50 per prescription
Drug definition	Mandatory generic substitution required
Certain vaccines, serums and injectable drugs*	50% paid
Smoking cessation drugs	50% paid to $1,000 lifetime maximum
Paramedical services (e.g., massage therapy, physiotherapy)	50% paid to a $500 Plan year maximum per practitioner
Mental Wellbeing Services**	**Effective April 1, 2022** - 100% paid to a $10,000 Plan year maximum
Private duty nursing	50% paid to a maximum of $50,000 every 3 Plan years
Medical supplies and services	50% paid
Hearing aids	50% paid to $500 for each ear, every 5 Plan years
Custom-made orthopedic shoes	50% paid for 1 pair per Plan year
Vision care††	100% paid to $200 every 2 Plan years
Semi-private hospital room	100% paid
Private hospital for mental health, substance abuse and addiction care***	100% paid
Fertility drugs & treatment	**Effective April 1, 2022** - 100% paid to $10,000 lifetime maximum
Adoption benefits****	**Effective April 1, 2022** - 100% paid to $10,000 lifetime maximum
Surrogacy benefits****	**Effective April 1, 2022** - 100% paid to $10,000 lifetime maximum
Gender Affirmation Treatment	100% paid to a $50,000 lifetime maximum
Referral Coverage*****	100% of daily/trip limits paid to a $50,000 lifetime maximum
TELUS Health Virtual Care	100% paid
Survivor Health Benefits†	Bank-paid coverage for 2 years
Wellbeing Programs and Services	Teladoc Medical Experts, Employee and Family Assistance Program, Carepath, Kids & Company, Manulife Vitality, WorkPerks, TutorBright and LifeSpeak

2) Core insurance coverage for you:

Coverage	Details
Short-term Disability	Benefit varies by years of service for approved absences of up to 26 weeks
Employee Life Insurance	1x Benefits Salary (to a maximum Benefits Salary of $250,000)

Employee-paid Core Coverage includes:

Long-term Disability insurance coverage for you

Coverage	Details
Long-term Disability coverage †	35% of the first $60,000 of Benefits Salary and 25% of Benefits Salary above $60,000, to a maximum Benefits Salary of $250,000 If your Benefits Salary is greater than $100,000 you have the option to limit your coverage and premiums to a Benefits Salary of $100,000

* The Plan does not cover the cost to administer serums, vaccines and injectable drugs; it covers only the cost of the drug itself.
** Practitioners are clinical counsellors, family therapists, internet-based cognitive behavioural therapy, marriage counsellors, masters of social work, psychologists and psychotherapists.
*** Refer to page 14 for a list of private hospitals included in this benefit
**** Any expenses reimbursed are considered taxable income and reported as income to you.
***** For non-medical expenses if you have prior approval from your provincial health plan for care out of province/Canada
† Contract employees are not eligible
†† Cost of eye exam is included in the maximum

What is your Benefits Salary?

If you are a regular full-time employee, your Benefits Salary is your annual base salary. It may include shift allowance, but excludes overtime and Annual Incentive Payments. For other employees, the Benefits Salary is calculated every year as follows (up to $250,000 for Long-term Disability and Core Employee Life insurance):

Commission-based (variable-pay employees):
Base salary, plus the average of the previous three years' commissions and various payments, if they apply.

Part-time employees:
Annualized rate of pay based on your regularly scheduled hours, but excluding overtime and Annual Incentive Payments.

Health Benefits

What you should know

- Your Bank-paid Core Coverage includes Health coverage for you, with the option to include your spouse and/or eligible dependents. You can buy additional Optional Health Coverage through credits and payroll deductions.
- The dependent coverage you select under the Core Health Plan will carry over into Optional Health if you elect to buy-up coverage.
- Your credits help pay for the optional benefits you choose for you and your eligible dependents.
- Health Benefits are administered by The Manufacturers Life Insurance Company (Manulife).
- Your Core and Optional Health coverage under the Canadian Benefits Plan supplements, and does not replace, the available benefits under any provincial health care plan.

Coverage options

To help you choose the coverage that best meets the needs of you and your eligible dependents, the Plan offers four options, ranging from Bank-paid Core Health Coverage to the most comprehensive level of Optional Coverage in Option 3.

Benefit	Bank-paid Core Coverage (Core Health)	Optional Coverage		
		Option 1	Option 2	Option 3
Prescription drug reimbursement	50% paid	60% paid	80% paid	90% paid
Annual out-of-pocket maximum	$6,000 for you and your eligible dependents combined for eligible health claims			
Dispensing fee cap	$8.50 per prescription			
Drug definition	Mandatory generic substitution required			
Certain vaccines, serums and injectable drugs*	50% paid	60% paid	80% paid	90% paid
Smoking cessation drugs	50% paid to $1,000 lifetime maximum	60% paid to $1,000 lifetime maximum	80% paid to $1,000 lifetime maximum	90% paid to $1,000 lifetime maximum
Sexual dysfunction drugs	Not covered	60% paid to $500 Plan year maximum	80% paid to $500 Plan year maximum	90% paid to $500 Plan year maximum
Paramedical services (e.g., massage therapy, physiotherapy)	50% paid to a $500 Plan year maximum per practitioner	60% paid to $500 Plan year maximum per practitioner	80% paid to $750 Plan year maximum per practitioner	90% paid to $1,000 Plan year maximum per practitioner
Mental Wellbeing Services**	**Effective April 1, 2022** - 100% paid to a $10,000 Plan year maximum			
Private duty nursing	50% paid to a maximum of $50,000 every 3 years	60% paid to a maximum of $50,000 every 3 years	80% paid to a maximum of $50,000 every 3 years	90% paid to a maximum of $50,000 every 3 years
Medical supplies and services	50% paid	60% paid	80% paid	90% paid
Hearing aids	50% paid to $500 for each ear, every 5 Plan years	60% paid to $500 for each ear, every 5 Plan years	80% paid to $1,000 for each ear, every 5 Plan years	90% paid to $1,500 for each ear, every 5 Plan years
Custom-made orthopedic shoes	50% paid, 1 pair per Plan year	60% paid, 1 pair per Plan year	80% paid, 1 pair per Plan year	90% paid, 1 pair per Plan year
Custom-made orthotics	Not covered	60% paid to $200, every 2 years	80% paid to $200, every 2 years	90% paid to $200, every 2 years
Vision care††	100% paid to $200 every 2 years	100% paid to $200 every 2 years	100% paid to $300 every 2 years	100% paid to $400 every 2 years
Semi-private hospital room	100% paid			
Private hospital for mental health, substance abuse and addiction care ***	100% paid			
Fertility drugs & treatment	**Effective April 1, 2022** - 100% paid to $10,000 lifetime maximum			
Adoption benefits****	**Effective April 1, 2022** - 100% paid to $10,000 lifetime maximum			
Surrogacy benefits****	**Effective April 1, 2022** - 100% paid to $10,000 lifetime maximum			
Gender Affirmation Treatment	100% paid to a $50,000 lifetime maximum			
Referral Coverage*****	100% of daily/trip limits paid to a $50,000 lifetime maximum			
TELUS Health Virtual Care	100% paid			
Wellbeing Programs and Services	Teladoc Medical Experts, Employee and Family Assistance Program, Carepath, Kids & Company, Manulife Vitality, WorkPerks, TutorBright and LifeSpeak			
Survivor Health Benefits†	Bank-paid coverage for 2 years			

Note: Reimbursement level for all health services will be based on reasonable, usual and customary charges.

* The plan does not cover the cost to administer serums, vaccines and injectable drugs; it covers only the cost of the drug itself.
** Practitioners are clinical counsellors, family therapists, internet-based cognitive behavioural therapy, marriage counsellors, masters of social work, psychologists and psychotherapists.
*** Refer to page 14 for a list of private hospitals included in this benefit
**** Any expenses reimbursed are considered taxable income and reported as income to you.
***** For non-medical expenses if you have Prior Approval from your provincial health plan for care out of province/Canada
† Contract employees are not eligible.
†† Cost of eye exam is included in maximum.

What are reasonable, usual and customary charges? Reasonable, usual and customary charges are the lowest of the following:

- The usual charge for the same or comparable service or supply in the area in which the charge is incurred, as decided by the administrator
- The amount shown in the applicable professional association fee guide, and
- The maximum price established by law

Eligibility

In addition to the plan's eligibility rules (see page 7), you and your dependents must be covered by your provincial or territorial health plan to be eligible for Health coverage.

What is covered

Your Health coverage reimburses you for a range of services and supplies. Eligible, expenses must be medically necessary, based on reasonable, usual and customary charges, and prescribed by a physician or registered practitioner.

Annual out-of-pocket maximum

All options under Health feature a $6,000 annual out-of-pocket maximum per certificate – the combined out-of-pocket payments for you, and your covered eligible dependents. If you and your covered eligible dependents pay $6,000 out-of-pocket for any eligible health expenses in a Plan year, any further eligible expenses will be covered at 100% for the rest of the Plan year.

Prescription drugs

Subject to the rules and/or limitations described below, the following services and supplies are covered:

- Any drug approved by Manulife for coverage, that legally requires a prescription, or is a prescribed life-sustaining drug
- Diabetes medication and supplies including non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)
- Injected serums
- Injected vitamins used to treat a deficiency
- Intrauterine devices and diaphragms
- Oral contraceptives
- Syringes

DrugWatch – Manulife's drug management program

Effective April 1, 2016, Manulife's DrugWatch program was applied to drug coverage under the Plan. Manulife's DrugWatch program provides more rigorous screening of new high-cost drugs, as well as of new uses for existing drugs, with a focus on cost and health outcomes. Specifically, the program examines the price and effectiveness of a small number of new high cost drugs or a new use for an existing drug versus comparable drugs for the same condition.

Drugs under DrugWatch review on or after April 1, 2016 will not be covered by the Plan unless and until subsequently approved.

- If approved, coverage is effective only for prescriptions issued on or after the date that the drug is approved by DrugWatch.
- If declined, the drug will not be covered by the Plan.

You can find out if a drug is being reviewed or has been declined by DrugWatch by:

- Searching for the drug using the *My drug plan* look-up tool. If a drug is under review by DrugWatch, you will be informed that it is not currently eligible for coverage.
- Contacting Manulife directly at 1-800-268-6195 and speaking with a Customer Service Representative. You can ask a Customer Service Representative to notify you if the drug is subsequently approved by DrugWatch for coverage.

A potential benefit of the DrugWatch program for Scotiabankers is mitigation of future health plan price tag increases through the management of high-cost drug claims.

Mandatory generic substitution

You'll be reimbursed for up to the amount of the lowest cost generic equivalent for prescription drugs. If you buy a brand name drug when a generic equivalent is available, you'll have to pay the difference unless your physician clearly states no substitutions, and Manulife approves the request.

Dispensing fee cap

A maximum or "cap" of $8.50 is set on the dispensing fee reimbursed per prescription. The dispensing fee is the professional fee a pharmacist charges for advice and dispensing medications. These fees vary among pharmacies. If the dispensing fee you are charged is higher than $8.50, you will have to pay the difference.

Quantity limits

The quantity of prescription drugs that can be dispensed and that you can claim at one time is limited to the least of the following:

- The quantity prescribed by your physician or dentist, or
- A 34-day supply.

Up to a 100-day supply may be payable for long-term therapy if recommended by your physician and pharmacist.

Optional Home Delivery of Prescriptions

For your convenience you can choose to purchase some or all of your maintenance drugs by home delivery from Express Scripts Canada.

A maintenance drug is a drug that you take regularly to treat ongoing medical conditions, such as asthma, high blood pressure or high cholesterol. The Express Scripts Canada Member Contact Centre can confirm if the drug you are taking is considered a maintenance medication.

What is covered continued

The amount payable is subject to any drug dispensing fee maximum and reimbursement level based on the Health coverage option you select (see table on page 10).

You can visit the Express Scripts Canada Pharmacy Online Prescription Manager at www.member.express-scripts.ca and enter the VIP code: BNS. You can also join by calling Express Scripts Canada Member Contact Centre at 1-855-550-6337. Have your drug card and your current maintenance medications on hand.

Residents of Quebec can learn how they might be able to reduce maintenance drug costs by calling PharmaGO at 1-855-333-3977.

Specialty Drug Care

Manulife's Specialty Drug Care program offers savings on high cost drugs and the support of a nurse case manager for individuals taking medications to treat a complex, chronic or life threatening conditions such as: rheumatoid arthritis; Crohn's disease; multiple sclerosis (MS); pulmonary arterial hypertension (PAH); cancer; osteoporosis and hepatitis C.

When you have a new prescription for drugs included in the program, you will be contacted directly by a nurse case manager to explain the program. The nurse case manager is there to help make arrangements for you to get your medication and to help you manage your condition.

If you want to learn more about Specialty Drug Care, call the toll-free number 1-844-MSDCARE (1-844-673-2273).

Plan ahead if you're going to be away from home:

If you're going to be away, and are nearing the end of your prescription, call Manulife directly at 1-800-268-6195 if you need to request an exception to quantity limits.

Find out about any limits and exclusions

Before incurring a major planned health expense, call Manulife directly at 1-800-268-6195 to find out if there are any other exclusions or limits that are not listed here.

Adoption Benefit:

- The child being adopted must be under age 18 and cannot be the child of the Scotiabank employee, their spouse or domestic partner.
- If both parents are Scotiabank employees, only one employee may apply for reimbursement for the same child.
- Expenses are NOT eligible for reimbursement until after the completion of the adoption.
- In order to be eligible for any reimbursement, must have been incurred and paid for by the employee while the employee was employed by the Bank AND is conditional on the employee being employed by the Bank on the reimbursement date.
- Expenses reimbursed under the Scotiabank surrogacy benefit are not eligible for reimbursement under the adoption benefit for the same child.
- Expenses are deemed eligible if they are reasonable and necessary and directly related to the adoption of a child.
- Eligible expenses include, but are not limited to:
  - Fees paid to an adoption agency licensed by a provincial or territorial government;
  - Court costs and legal and administrative expenses related to an adoption order in respect of the adopted child;
  - Travel expenses of the adopted child and the adoptive parents to gain physical custody of the adopted child;
  - Lodging and food expenses for the adopted child and the adoptive parents when required to travel to complete the adoption;
  - Document translation fees;
  - Mandatory expenses paid in respect of the immigration of the adopted child to Canada;
  - Home study fees and expenses related to the psychosocial assessment of the adoptive parents;
  - Charges for temporary foster care before placement; and
  - Any other reasonable expenses related to the adoption required by a provincial government or an adoption agency licensed by a provincial government.

What is covered continued

Surrogacy Benefit:

- Eligible expenses are those paid by an employee and either are incurred by surrogate mothers, sperm and/or ova donors or relate to the maintenance or transport of an in vitro embryo in relation to a surrogacy and in either case are identified as eligible for reimbursement under the Assisted Human Reproduction Act (AHRA).
- Expenses are NOT eligible for reimbursement until after the end of the contractual surrogacy agreement between the parties.
- In order to be eligible for any reimbursement, must have been incurred and paid for by the employee while the employee was employed by the Bank AND is conditional on the employee being employed by the Bank on the reimbursement date.
- Expenses reimbursed under the Scotiabank adoption benefit are not eligible for reimbursement under the surrogacy benefit for the same child.
- Eligible expenses include, but are not limited to:
  - Travel expenses (within Canada) as incurred for legal, clinical, medical, and counseling appointments associated with the surrogacy
  - Reasonable lodging and food expenses where travel (within Canada) is more than two hours one way for legal, clinical, medical, or counseling appointments associated with the surrogacy;
  - Expenditures for psychosocial and genetic counselling services
  - Expenditures for legal services and disbursements relating to the negotiation of the surrogacy arrangement and acquiring legal parental rights;
  - Medical expenses for the surrogate mother (as a result of the surrogacy), including:
  - Expenditures for obtaining any drug or device as defined in section 2 of the Food and Drugs Act;
  - Expenditures for obtaining products or services that are provided or recommended in writing by a person authorized under the laws of a province to practice medicine and to assess, monitor and provide health care to a woman during her pregnancy, delivery or the postpartum period;
  - Expenditures for obtaining a written recommendation for the products or services referenced above;
  - Expenditures related to the delivery;
  - Expenditures for prenatal exercise classes; and
  - Expenditures for health, disability, travel or life insurance coverage for the surrogate mother.
  - Expenditures for obtaining or confirming medical or other records;
  - Expenditures for the maintenance of an in vitro embryo, including storage;
  - Expenditures for the transport of an in vitro embryo including preparing for transport, for the shipping container and for preparing the container for transport;
  - Loss of work-related income incurred during pregnancy for the surrogate mother if a qualified medical practitioner certifies in writing that continuing work may pose a risk to the surrogate mother or that of the embryo or fetus; and the reimbursement is made in accordance with AHRA.

Paramedical services

Treatment costs, after the provincial maximum is reached, from any of the following licensed or registered health professionals are covered:

- Acupuncturists
- Chiropractors
- Massage therapists
- Naturopaths
- Occupational therapists
- Osteopaths
- Physiotherapists
- Podiatrists and chiropodists (combined)
- Speech-language therapists

The Plan year maximum coverage limits shown under each Health coverage option apply per type of practitioner, per covered person per Plan year, with the exception of chiropodists and podiatrists, who have a combined annual maximum.

Your provincial or territorial health plan may pay part of the expense for some paramedical services. If it does, your coverage will apply to eligible expenses after your annual provincial or territorial maximum is reached.

What is covered continued

Private duty nursing

Private duty (or in-home) nursing provides in-home care, usually from qualified health-care professionals such as a registered nurse (RN) or licensed practical nurse (LPN). This coverage is limited to $50,000 per three consecutive Plan years. Coverage does not include custodial care, homemaking duties, supervision services or nursing care by a relative or person who lives in your home.

Plan your expenses

If you expect that you or a dependent will require nursing care, you should give Manulife a detailed treatment plan – provided by your physician – and cost estimate to find out how much will be reimbursed under your Health coverage.

Medical supplies and services

You'll be reimbursed for the following supplies and services. Any coverage limits that apply appear beside the relevant items. Your coverage does not include medical equipment provided by a hospital.

- Ambulance: transportation in a licensed ambulance within your home province or territory (includes air ambulance)
- Braces (not foot braces or dental braces), casts, splints, collars and trusses
- Breast prostheses (one per breast per Plan year)
- Dental charges for the treatment of an injury to natural teeth or jaw if you receive treatment within 12 months of the accident, excluding any injury from biting or chewing
- Glasses, if needed and prescribed as a result of cataract surgery (one pair per lifetime)
- Manually operated hospital beds and other hospital equipment usually found only in hospitals
- Ileostomy and colostomy supplies
- Incontinence supplies
- Medicated dressings and burn garments
- Mobility equipment – crutches, canes, walkers and wheelchairs
- Myoelectric prosthetic devices (up to $15,000 in each five consecutive Plan years)
- Oxygen
- Respiratory and oxygen equipment
- Sclerotherapy (up to $250 per visit, including physician's fees)
- Surgical brassieres (four per Plan year)
- Surgical support stockings (up to $400 per Plan year)
- Wigs and hairpieces for temporary hair loss associated with medical treatment (up to $500 per lifetime)

Hearing aids

The cost of fitting, repairing and maintaining hearing aids is covered, excluding batteries. The maximum coverage is set for each ear, for each covered person.

Orthotics and orthopedic shoes

One pair of custom-made orthopedic shoes is covered per Plan year under all coverage levels, at the reimbursement percentage that applies. Custom-made orthotic foot appliances are covered under Health Coverage Options 1, 2 and 3 only.

All orthotics and orthopedic shoes must be recommended by a physician or podiatrist.

Semi-private hospital room accommodation

Semi-private hospital accommodation is available to you. It reimburses the difference between the cost of staying in a semi-private hospital room and a standard room, which your provincial or territorial health plan covers.

Private hospital for mental health, substance abuse and addiction care

Covered, based on Reasonable and Customary amounts. Hospitals include:

- Bellwood Private Hospital
- Centre for Addiction & Mental Health (CAMH)
- Donwood
- Homewood Health Centre
- Institute of Psychotherapy
- Oaks Centre/Camillus Centre
- Shouldice Hospital

If your preferred hospital is not listed above, call Manulife directly at 1-800-268-6195 to confirm if it's eligible.

Note that coverage is for accommodations only. Other expenses such as counselling may be eligible for reimbursement under the Mental Wellbeing Services benefit.

Vision Care

Your vision care coverage includes:

- Buying and fitting prescription glasses and contact lenses
- Eye examination
- Laser eye surgery

Visual training for eye laxity, up to a $200 lifetime maximum.

Gender Affirmation Treatment

The purpose of this coverage is related to masculinization or femininization, not elective cosmetic enhancement. All eligible services must be Medically Necessary and ordered by a Physician involved in the transitioning treatment.

What is Covered?

Charges for feminization procedures as follows:

- Breast/chest surgery - augmentation mammoplasty (implants/lipofilling)

What is covered continued

- Genital surgery - penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, scrotectomy, labiaplasty
- Non-genital, non-breast interventions - facial femininization surgery such as rhinoplasty, and blepharoplasty, abdominoplasty, liposuction, lipofilling, gluteal augmentation (implants/ lipofilling), hair reconstruction, electrolysis or laser hair removal of facial, body hair or skin graft, reduction thyroid chondroplasty and laryngoplasty/vocal cord surgery

Charges for masculinization procedures as follows:

- Breast/chest surgery - mastectomy, chest masculinization
- Genital surgery - hysterectomy, salpingo-oophorectomy, metoidioplasty or phalloplasty, urethroplasty, vaginectomy, glansplasty, scrotoplasty and insertion of testicular implants; and insertion of an erectile device
- Non-genital, non-breast interventions – facial masculinization surgery such as facial bone reconstruction, rhinoplasty and blepharoplasty, abdominoplasty, liposuction, lipofilling, pectoral.

Referral Coverage

Referral Coverage provides some financial support for non-medical expenses (transportation, accommodation and meals) incurred when you or your dependent requires medical treatment out of province or out of Canada, which is approved (with Prior Approval) and paid for by your provincial or territorial health plan.

The Referral Coverage benefit will provide the following in Canadian Dollars:

- Daily Maximums and Limits of:
  - $250 per day for 30 days for lodging, all forms of transportation and meals
  - $200/one-way trip for the caregiver accompanying the employee or Eligible Dependent as required
- Accumulating to a Lifetime Maximum of $50,000 per employee or Eligible Dependent

In addition to the plan's eligibility rules for employees and eligible dependents (see page 7), you and your dependents must be covered by your provincial or territorial health plan to be eligible for Health coverage.

Eligible Caregivers include:

- Your Spouse, including your common-law Spouse
- Your children and children of your Spouse
- Your mother, father and the spouse of either parent, including a common-law spouse
- Your grandparent, great-grandparent or grandchild and your Spouse's grandparent, great-grandparent or grandchild
- Your daughter-in-law and son-in-law
- Your brother, sister, brother-in-law, sister-in-law and their spouses, including common-law spouses
- Your mother-in-law, father-in-law and the spouse of your mother-in-law and father-in-law
- Your aunt, uncle, niece or nephew
- Your foster parent, ward or guardian
- Any relative who lived with you permanently
- A person you consider to be like a family member

What is Covered?

To be covered, claims under the Referral Coverage must include the following information at submission:

From the Provincial Health Plan:

1. Prior Approval decision letter outlining what service(s) have been approved, including
   a) Diagnosis; and
   b) Reason for referral (based on physician application and medical documentation)
2. The facility where the service(s) are to be provided, including city, province/state, country, and treatment date(s)
3. The approved cost of the service(s)
4. Fully itemized statements from the provider(s) of service and the corresponding statements of approval/denials from the provincial health plan

When submitting the Extended Health Care Claim form (online or paper), include the following:

1. Ensure all applicable sections of the claim form are completed and signed
2. Supporting information from the provincial health plan as indicated above (required)
3. Itemized receipts

Eligible expenses and services include:

- Meals with receipts
- Transportation (taxi, train, bus, airfare) with receipts
- Accommodation (hotel, extended stay suite) with receipts

Refer to the 'What is not covered' section below for any limitations and exclusions that apply to Referral Coverage.

What is covered continued

TELUS Health Virtual Care

TELUS Health Virtual Care provides you with 24/7 secure online access to Canadian healthcare professionals on demand. Get care through your mobile device or computer – when and where you need it.

- Available to you and your family members. Your eligible dependents are covered even if you elect single coverage for other benefits.
- You and your family members can use TELUS Health for many of the same things that you would usually go to your primary healthcare provider for, including:
  - Cold and flu
  - Depression and anxiety
  - Skin and eye issues
  - …and more
- TELUS Health can provide:
  - Diagnoses and advice
  - Prescriptions (new and renewals)
  - Lab and imaging orders
  - Specialist referrals
- With your consent, medical notes from your virtual consults can even be shared with your family doctor. Your medical information will never be shared with the Bank or with Manulife.

Plan your expenses

You can find a list of approved health care providers on Manulife's Plan Member Site through me@scotiabank > *Pay and Benefits > My Benefits > Canadian Benefits Plan Member Site > Wellness Centre.*

Note, it is your responsibility to review this list on a regular basis to ensure your commonly used providers are still approved prior to incurring the expense. Otherwise, your claim may not be eligible for reimbursement.

What is not covered

Your Health benefits do not cover any of the following services, unless otherwise specified:

- Administering costs for serums, vaccines or injectable drugs
- Drugs, biologicals and related preparations that are:
  - intended to be administered in a hospital as an in-patient or out-patient, rather than at home
  - payable by a provincial or territorial health plan
- Medical expenses related to:
  - Self-inflicted injuries
  - War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
  - Committing or attempting to commit an assault or criminal offence
  - Injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
  - An illness or injury for which benefits are payable under any government plan or workers' compensation program
  - Periodic checkups, missed appointments, third-party examinations, travel for health purposes or filling out claim forms
  - Experimental or investigatory medical treatment that is not usual or customary
  - Cosmetic medical or surgical care
- Services or supplies that are:
  - Provided by an employer's medical or dental department
  - Not permitted by law to be paid
  - Required for recreation or sports
  - Payable by a provincial or territorial health plan if applied for
  - Performed or provided by the covered person, an immediate family member or a person who lives with the covered person
  - Provided while admitted to a hospital as an in-patient
  - Not specified as a covered expense under this benefit
- Service or supplies that, if coverage wasn't in place:
  - Wouldn't be normally charged for, or
  - Would be reimbursed by a government-sponsored plan
- The following expenses are not eligible for reimbursement under the Surrogacy benefit:
  - Expenses related to an international surrogacy arrangement;
  - Expenses related to a surrogacy arrangement where the surrogate mother is not at least 21 years of age;
  - Adoption related expenses reimbursed under the Scotiabank adoption benefit;
  - Surrogacy agency fees or surrogacy consultant fees; and
  - Expenses paid in violation of provincial or federal law.
- The following limitations and exclusions apply to the Gender Affirmation Treatment:
  - Expenses related to travel or accommodation under this benefit. **This may be eligible under Referral Coverage. Please contact Manulife to confirm.**
  - Services obtained outside of Canada
  - Services that are considered cosmetic, except as otherwise provided under the list of eligible expenses as outlined in the feminization and masculinization procedures mentioned above
  - Expenses related to the reversal of gender affirmation treatments
  - Expenses related to sperm preservation and/or cryopreservation of fertilized embryos and expenses related to infertility
  - Any services/expenses payable under any Provincial Plan.
- The following limitations and exclusions apply to the Referral Coverage:
  - The referral outside of the home province or outside Canada must be medically necessary with Prior Approval (decision letter) for services and coverage (payment) from your provincial or territorial health plan.
  - Non-medical claims associated with referrals out of province or out of country must be approved by Manulife. Payment will only be made for accommodation, transportation and meals rendered while the patient was under the active treatment of a licensed physician. Itemized receipts must be submitted with all claims.
  - Claims submitted under this coverage must not be for services eligible under the Canadian Benefits Plan as determined by Manulife.
  - Non-medical expenses related to medical treatments covered by a provincial health plan and available in the employee's home province are not eligible under this benefit.
  - Payment will not be made for treatment of any illness diagnosed prior to the effective date of this coverage.
  - Payment will not be made for claims incurred prior to April 1, 2019 related to treatment out of province or out of country, regardless of Prior Approval from your provincial health plan.

Coverage if you live in Quebec

If you live in Quebec, here's how provincial legislation affects your Health benefits choices and coverage:

- Your Health coverage must meet the minimum requirements for coverage of prescription drugs on the Régie de l'assurance-maladie du Québec (RAMQ) formulary (drug list), which means you must buy either Health Coverage Option 2 or 3; you don't have to do this if you can prove that you have coverage under your spouse's health plan or another plan.
- You must cover all your eligible dependents if they're not already covered by your spouse's plan or another plan.
- If your dependent children are full-time students, they will be covered until they turn age 26.
- The dispensing fee maximum does not apply because the dispensing fee is not disclosed separately in Quebec.
- RAMQ sets the maximum out-of-pocket expense for drugs on the Quebec formulary. When you reach that limit, your Health benefits will pay 100% of any further expenses that year.
- Prescription drugs will be reimbursed based on RAMQ guidelines.
- A government formula determines the "value" of your coverage and you pay income tax at your provincial rate.

Survivor Health Benefits

If you die, the Health option you have at the time of your death will continue at no cost for your eligible dependents for two years. Eligible surviving dependents will not be able to change your Health option during a re-enrolment period within the two years. Contract employees are not eligible for Survivor Health Benefits.

If you have a Health Care Spending Account balance at the time of your death, your survivors can submit any eligible expenses that occur after your death to your Health Care Spending Account. The balance will be available until the end of the Plan year, when it will expire.

The same claim submission rules for the Health Care Spending Account will apply (see page 52).

Survivor Health Benefits will end on the earliest of these events:

- 24 months from your death,
- Your dependent no longer qualifies as a dependent,
- Your dependent has coverage under another plan, or
- The Plan ends.

Additional Personal Time

What you should know

- You have the opportunity to buy Additional Personal Time in 7.5 hour increments, up to a maximum of 37.5 hours, with credits.
- Additional Personal Time will be reflected in your Personal Time entitlement for the current calendar year, in April.
- Additional Personal Time purchase is only available during annual re-enrolment and cannot be purchased during a new hire and/or Work/Life Event enrolment window.
- If you buy Additional Personal Time, it must be taken within the current calendar year, similar to regular Personal Time. If you do not use your Personal Time by December 31st, it will expire.

Eligibility

All employees eligible for the Canadian Benefits Plan.

Carrying Personal Time forward

You can't carry forward any unused Personal Time balances from one year to the next. It expires at the end of the current calendar year (December 31).

Dental Benefits

What you should know

- Three Dental coverage options are available to you and your eligible dependents, each with different levels of reimbursement for services.
- Option 2 provides orthodontia services for children under age 19.
- Option 3 provides orthodontia services for you and your dependents.
- You will have the flexibility to buy Dental coverage for yourself and any eligible dependents you choose, regardless of the dependents you cover for Health benefits.
- The coverage option you select is paid by bank provided credits first, and if you do not have enough credits to purchase your desired benefit selection, you pay the remaining cost through payroll deductions.
- Dental Benefits are administered by The Manufacturers Life Insurance Company (Manulife).

Coverage options

Eligible dental services and supplies will be reimbursed at the percentage shown in the table to the limits indicated. Additional information about limits and conditions follows the table.

Benefit	Opt Out	Option 1	Option 2	Option 3*
Basic services, periodontics and endodontic**	N/A	50% paid	80% paid	90% paid
Major services**	N/A	50% paid	60% paid	70% paid
Annual maximum for basic and major services combined**	N/A	$1,000 per person	$1,500 per person	$2,000 per person
Orthodontics**	N/A	No coverage	50% paid to $1,500 lifetime maximum per child (for children under age 19 only)	60% paid to $2,500 lifetime maximum per dependent
Survivor dental benefits†	N/A	Bank-paid coverage for 2 years		

* Option 3 is locked in for 2 full Plan years (April 1 to March 31). Coverage cannot be decreased if you have not satisfied the 2 full Plan year lock-in period, even if you experience a Work/Life Event.
** Eligible Dental fees are determined based on your current *Provincial Fee Guide*. You are responsible for any additional fees over and above those listed in your *Provincial Fee Guide*
† Contract employees are not eligible

What is covered

The following services are covered under all three Dental coverage options, unless otherwise stated.

- Basic services, endodontic and periodontics
- Complete oral exam once every three years
- Full-mouth X-rays once every three years
- Panoramic X-rays once every three years
- One unit of light scaling and one unit of polishing, once every nine months for Options 1 and 2, and once every six months for Option 3
- Recall exams, bitewing X-rays (two films) and fluoride treatments, once every nine months for Options 1 and 2 and once every six months for Option 3
- Oral hygiene instruction, once per lifetime for dependent children under age 19 only
- Routine diagnostic and laboratory procedures
- Emergency and specific examinations
- Fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered if:
  - The existing filling is at least 12 months old and must be replaced due to significant breakdown or recurrent decay, or
  - The existing filling is amalgam and medical evidence indicates that the patient is allergic to amalgam.
- Prefabricated full coverage restorations (metal and plastic)
- Space maintainers (excludes appliances placed for orthodontic purposes)
- Minor surgical procedures and post-surgical care
- Extractions (including impacted and residual roots) consultation, anesthesia and conscious sedation
- Denture repairs, relines and rebases, only if the expense is incurred more than three months after the denture was first placed
- Injection of antibiotic drugs administered by a dentist in dental surgery
- Surgical procedures not covered under preventive services (excluding implant surgery)
- Periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
  - Scaling not covered under preventive services, and root planing, up to a combined maximum of 14 units per Plan year
  - Provisional splinting
  - Occlusal equilibration, up to a maximum of eight units per Plan year.

What is covered continued

- Endodontic services, which include root canals and therapy, root amputation, apexifications and periapical services, with the following limits:
  - Root canals and therapy are limited to one initial treatment plus one retreatment per tooth, per lifetime
  - Retreatment is covered only if the expense is incurred more than 12 months after the initial treatment.

Major services

- Crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay
- Removable full or partial dentures
- Replacement of removable dentures, if you need the dentures because:
  - A natural tooth is extracted and the existing dentures cannot be used,
  - The existing dentures are at least 60 months old, or
  - The existing dentures are temporary and are replaced with permanent dentures within 12 months of installation.
- Inlays, covering at least three surfaces, if the tooth cusp is missing
- Implants
- Initial provision of fixed bridgework
- Replacement of bridgework, if the new bridgework is required because:
  - A natural tooth is extracted and the existing appliance cannot be made serviceable
  - The existing appliance is at least 60 months old, or
  - The existing appliance is temporary and is replaced by a permanent bridge within 12 months of the initial temporary installation.

Dentures or bridgework required to replace a natural tooth are not covered if the tooth was missing before coverage began under any of the Dental options.

Orthodontics

Option 2 covers services and supplies related to orthodontic treatment for your eligible dependent children under age 19 only. Option 3 provides coverage for you and your dependents.

Predeterminations can help you plan your expenses

If you think your dental expenses will cost more than $500, ask your dentist to send a cost estimate, or a "predetermination" to Manulife. Manulife will then tell you the amount you'll be reimbursed for.

What is not covered

Dental expenses that result from any of the following causes or situations are not covered:

- Self-inflicted injuries
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- Committing or attempting to commit an assault or criminal offence
- Injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- Cosmetic dental care , unless it is due to an accidental injury that occurred while the patient was covered under this benefit
- Anti-snoring or sleep apnea devices
- Missed dental appointments, third-party examinations, travel to and from appointments, or filling out claim forms
- Services payable by any government plan
- Services or supplies provided by an employer's medical or dental department
- Services or supplies that wouldn't normally be charged for if coverage was not in place
- Treatment of a full-mouth reconstruction, vertical dimension correction or correction of temporomandibular joint dysfunction
- Replacement of lost, stolen or mislaid removable dental appliances
- Laboratory fees that exceed reasonable and usual charges
- Services or supplies performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- Treatment that the dental profession doesn't generally recognize as effective, appropriate and essential for the dental condition
- Services or supplies not specified as a covered expense under this benefit.
- Specialist fees

What is the Alternate Benefit Clause?

This clause in your Dental coverage says that if more than one dental treatment option is available, you'll be reimbursed for the least expensive treatment that provides the same professionally adequate result. Manulife's professional dental consultant will help determine the maximum amount covered.

Survivor Dental Benefits

If you die and your dependents are covered for Dental, the Dental option you have at the time of your death will continue at no cost for your eligible dependents for two years. Eligible surviving dependents will not be able to change your Dental option during a re-enrolment period within the two years. Contract employees are not eligible for Survivor Dental Benefits.

If you have a Health Care Spending Account balance at the time of your death, your survivors can submit any eligible expenses that occur after your death to your Health Care Spending Account. The balance will be available until the end of the Plan year, when it will expire. The same claim submission rules for the Health Care Spending Account will apply (see page 52).

Survivor Dental Benefits will end on the earliest of these events:

- 24 months from your death,
- Your dependent no longer qualifies as a dependent,
- Your dependent has coverage elsewhere, or
- The Plan ends.

Short-term Disability Benefits

What you should know

- Short-term Disability pays benefits if you are away from work due to an approved illness or injury for more than three consecutive, regularly-scheduled workdays. This benefit is provided at no cost to you.
- You can receive Short-term Disability Benefits for up to 26 weeks for an approved illness or injury. Longer periods of disability may be eligible for coverage under the Long-term Disability benefit. Short-term Disability coverage is based on your Benefits Salary and length of service (see chart below).
- Short-term Disability Benefits are administered by The Manufacturers Life Insurance Company (Manulife).
- Short-term Disability Benefits are paid biweekly if you are away from work due to an approved illness or injury for more than three consecutive, regularly-scheduled workdays. You can receive Short-term Disability Benefits for up to 26 weeks. Short-term Disability coverage is based on your Benefits Salary.
- Manulife will also provide personalized, comprehensive case management to support your recovery while you're receiving Short-term Disability Benefits.

Eligibility

All regular full-time or part-time employees are eligible for Short-term Disability coverage from their date of hire. If you're a contract employee, you must have one year of continuous employment under the same employee number.

To qualify for Short-term Disability Benefits, you must:

- Provide medical documents, when asked, to confirm that you are unable to perform your regular job's essential or modified duties because of a medically substantiated condition.
- Be under the care of a certified medical physician who is licensed to practise medicine in Canada.
- Be approved for Short-term Disability Benefits by Manulife.
- Participate in your recovery process by complying fully with the recommended Active Treatment Plan, including any Rehabilitation or Modified Work Programs, developed by Manulife with input from both you and your physician.

Coverage levels

Short-term Disability Benefits are based on your Benefits Salary.

	Full-time and Part-time Regular and Contract Employees*	
Length of Employment (from last date of hire)	**Maximum period at 100% of Benefits Salary**	**Maximum period at 75% of Benefits Salary**
Less than 10 years	8 weeks	18 weeks
10 years or more	26 weeks	N/A

* One week is equal to the standard number of days/hours in the employee's workweek.

When benefits will be paid

If you're unable to return to work after three consecutive days of absence due to an illness or injury, you may qualify for Short-term Disability Benefits if Manulife approves your absence. The benefit payments are equal to part or all of your Benefits Salary, as described in the Coverage level chart. Your Short-term Disability leave may continue for up to 26 weeks if you qualify.

After the 26-week period, you may qualify to receive Long-term Disability Benefits if you remain disabled.

When to apply for Short-term Disability Benefits

If you think you'll need to be away from work for more than one full workweek (the number of days/hours in a week you usually work), you should apply for Short-term Disability Benefits. You must call your Manager/Supervisor to report your absence. See me@scotiabank > *Ask HR* for more details.

When benefits will not be paid

You will not receive Short-term Disability Benefits if you are:

- On a leave of absence (other than the health-related portion of your maternity leave)
- On vacation, or receiving vacation pay and not actively working
- Not under the care of a certified physician licensed to practise medicine in Canada
- Not under the care of a certified physician licensed to practise medicine in Canada and who specializes in the area of your disabling condition, if a specialist is required
- Not participating in the initial telephonic assessment with Manulife
- Refusing to communicate with your Manulife case manager
- Refusing to have an Independent Medical Evaluation, if one is requested by either the Bank or Manulife
- Not complying fully with your recommended Active Treatment Plan
- Not receiving continuous treatment in a recognized intensive treatment program for drug or alcohol use when your illness, or reason for absence, results from using these substances
- In a secured psychiatric facility, jail, prison or any correctional facility because of a criminal offence
- Injured as a result of service in the armed forces or reserves
- Suspended with pay, pending the outcome of an investigation into a performance or conduct issue
- Suspended without pay under the Performance Improvement Program
- Receiving salary continuation as part of reasonable notice of termination [*subject to statutory requirements]
- Terminated from your employment, or
- Taking vacation during your Short-term Disability leave as you are expected to be focusing on recovery and participating in your treatment plan, attending appointments, etc.

  If you had been previously approved for vacation time prior to your approved Short-term Disability leave, the time will be added back to your vacation allotment.

You are also excluded when you are absent due to:

- Plastic surgery solely for cosmetic purposes, except when it's due to an illness or injury
- A disabling illness or injury resulting from:
  - your participation in a criminal act or provoking an assault, including operating a motorized vehicle while over the legal alcohol limit, even if you are not formally charged,
  - your participation in a riot, insurrection or civil commotion, or perpetration of acts of terrorism, or
  - Intentionally self-inflicted injuries.
- Declared or undeclared war, or any act of war if you are:
  - not on a business trip for the Bank, or
  - on a business trip for the Bank in Canada or the United States.

Other situations may also affect your Short-term Disability eligibility, or end or reduce your Short-term Disability payments. These include having a second job, money recovered from a third party, government disability benefits and work-related illness or injury. If you recover funds from a third party (i.e. due to legal proceedings, automobile insurance, Canada/Quebec Pension Plan) for loss of income that has already been paid through the Short-term Disability plan you must reimburse the Bank for the amount recovered (i.e. from the third party) up to, but not exceeding, the amount you have already received from the Plan in respect of Short-term Disability Benefits payments.

If you begin a Short-term Disability leave, you'll be provided with detailed information about your responsibilities (see me@scotiabank > *Ask HR*) and how you can work with Manulife towards a timely and safe return to health.

Continuation of other benefits

While you're receiving Short-term Disability Benefits, your other Plan benefits and payroll deductions will continue at the same level as when you started your Short-term Disability leave. You'll also continue to accumulate vacation time.

If you experience a Work/Life Event while on Short-term Disability:

- You may not increase your Optional Life insurance, Accidental Death & Dismemberment or Critical Illness insurance or change your Long-term Disability coverage
- You may decrease, but not increase your Health or Dental coverage
- Dental Option 3 cannot be decreased if you have not satisfied the two- full-plan year lock-in period

If annual re-enrolment occurs while you are on Short-term Disability:

- You may not increase your Optional Life insurance, Accidental Death & Dismemberment or Critical Illness insurance, or change your Long-term Disability coverage.
- You may increase or decrease your Health or Dental coverage.
- Dental Option 3 cannot be decreased if you have not satisfied the two-full-plan year lock-in period.

If you're on Short-term Disability and expecting a baby

See me@scotiabank > *Ask HR* to learn how your Short-term Disability coverage works with the Bank's supplements to the government's Employment Insurance (EI) maternity plan or the Quebec Parental Insurance Program.

Returning to work from Short-term Disability leave

The Plan focuses on your recovery, and your safe and timely return to healthy and productive functioning at work and at home.

While you are working Rehabilitation hours or on a Modified Work Program,

- You will continue to be on approved Short-term Disability leave and the 26-week maximum from date of disability applies.
- The income you receive is based on your Short-term Disability benefit plus your part-time rehabilitation earnings, up to a maximum amount that is equal to your Benefits Salary.
- The total amount received from the Short-term Disability plan and rehabilitation employment cannot exceed 100% of your Benefits Salary.
- Your rehabilitation earnings are the hourly equivalent of your annual Benefits Salary.

Recurring disabilities

If your disability recurs after you return to work, the following rules apply:

	Return to work for less than one day	**Return to work for more than one day but less than 30 calendar days**	**Returned to your regular job (i.e. pre-disability absence) or standard weekly position hours corresponding to your position full-time equivalent (FTE) for 30 calendar days**
If you experience a recurrence of the same or related disability	Your current Short-term Disability claim will continue. The maximum benefit period of 26 weeks, from the date of the original absence, will apply.	Your current Short-term Disability claim will continue. The maximum benefit period of 26 weeks, from the date of the original absence, will apply.	You will submit for a new claim for Short-term Disability. The maximum benefit period of 26 weeks from the date of the absence will apply.
If you experience a new, unrelated disability	Same as above. Your current Short-term Disability claim will continue.	You will submit for a new claim for Short-term Disability. The maximum benefit period of 26 weeks from the date of the absence will apply.	Same as above. You will submit for a new claim for Short-term Disability.

Note:

1. You will not be required to use another three Sick or Personal Obligation Days for the first three days of absence if your current Short-term Disability claim continues in the applicable scenarios above.
2. If you were previously ineligible for Short-term Disability Benefits, you will continue to be ineligible for Short-term Disability Benefits

Long-term Disability Benefits

What you should know

This benefit information is based on the plan coverage in effect as of April 1, 2017.
If your date of disability is prior to April 1, 2017, then please call HR Services for disability benefit information.

- Long-term Disability pays monthly benefits if you are away from work for more than 26 weeks due to an approved illness or injury. Long-term Disability starts when Short-term Disability Benefits end for a seamless transition.
- Your employee-paid Core Long-term Disability coverage includes Long-term Disability benefits of 35% of the first $60,000 of Benefits Salary and 25% of Benefits Salary above $60,000 (to a maximum Benefit Salary of $250,000).

  If your Benefits Salary is greater than $100,000 you have the option to limit your coverage and premiums to a Benefits Salary of $100,000. If you choose to limit your coverage, you must submit Evidence of Insurability, if you later wish to increase your coverage to the higher salary level.
- Optional Long-term Disability coverage is available and includes Long-term Disability Benefits of:
  - 55% of the first $30,000 of Benefits Salary, 45% of the next $60,000 of Benefits Salary and 35% of Benefits Salary above $90,000 (to a maximum Benefit Salary of $250,000).
- Premiums for Core and Optional Long-term Disability coverage are fully paid by you and therefore any benefits received when a claim is approved are not subject to tax.
- At your first enrolment, you can select Core Long-term Disability coverage without Evidence of Insurability. You must provide Evidence of Insurability if you select Optional Long-term Disability coverage.
- Once you are in receipt of Short-term or Long-term Disability Benefits, the coverage level you have selected may not be changed until you return to work.
- The Plan sets a limit on your combined income from all sources during your Long-term Disability leave – this is called the "all-source maximum." (See page 29 for more information.)
- If you wish to increase your existing coverage, you will need to provide Evidence of Insurability.
- If your Benefits Salary changes during the Plan year, your coverage level and premium will automatically increase.
- Long-term Disability Benefits are provided by Canada Life Assurance Company. Canada Life will also provide you with personalized, comprehensive case management to support your recovery while you're receiving Long-term Disability Benefits.
- If you have individual Long-term Disability policies elsewhere, you are still required to participate in the Canadian Benefits Plan as a condition of employment and, in order to participate in the Canadian Benefits Plan, you are required to purchase Employee-paid Core Long-term Disability coverage.

Coverage options

Long-term Disability Options	
Core Long-term Disability Coverage	35% of the first $60,000 of Benefits Salary and 25% of Benefits Salary above $60,000 (to a maximum Benefit Salary of $250,000). If your Benefits Salary is greater than $100,000 you have the option to limit your coverage and premiums based on a Benefits Salary of $100,000.
Optional Long-term Disability coverage	55% of the first $30,000 of Benefits Salary, 45% of the next $60,000 of Benefits Salary and 35% of Benefits Salary above $90,000 (to a maximum benefit salary of $250,000).

Eligibility

The plan's eligibility rules (see page 7) apply to regular full-time and regular part-time employees. Contract employees are not eligible for Long-term Disability Benefits.

To qualify for Long-term Disability Benefits, you must:

- Meet the definition of disability (see below).
- Not have specified pre-existing conditions (see page 28).
- Provide the medical documentation, required by Canada Life, to confirm your inability to work as per the definition of disability.
- Be under the care of a certified specialist for the condition involved, where considered appropriate by Canada Life for the severity of the condition.
- Be approved for Long-term Disability Benefits by Canada Life.
- Participate in your recovery process by complying fully with the recommended Active Treatment Plan, including any rehabilitation or modified work programs, developed by Canada Life with input from both you and your physician.

When Long-term Disability coverage ends

In addition to the Plan's eligibility rules (see page 7), you'll no longer be eligible for Long-term Disability coverage on the earlier of:

- The day you become age 64 years, 6 months old,
- The date this policy terminates, and
- The day you no longer qualify for Long-term Disability.

Long-term Disability insurance will not be extended during the period subsequent to notice of termination of employment, except as is required by law.

Evidence of Insurability

Once you're enrolled in the Plan, you must provide Evidence of Insurability to request an increase in your coverage at future enrolments.

When benefits will be paid

Long-term Disability Benefits are based on your annual Benefits Salary (see page 9). You'll find details of the coverage options in the chart on page 26. Long-term Disability benefits will be paid if:

- The 26-week Long-term Disability waiting period has expired, and
- You meet the following definition of disability

For the first 12 months of Long-term Disability Benefits, you are considered disabled if:

- You're unable to perform the essential duties of your regular occupation, and
- You're not working in a job that is providing you with income equal to or greater than the Long-term Disability income benefit, except for jobs under an approved rehabilitation program.

After 12 months of Long-term Disability Benefits, you are considered disabled if disease or injury prevents you from being gainfully employed. Gainful employment means work:

- That you are medically able to perform,
- For which you have at least the minimum qualifications,
- That provides income of at least 60% of your monthly earnings, and
- That exists either in the province or territory where you worked when you became disabled or where you currently live.

The availability of work will not be considered in assessing your ability for gainful employment.

When benefits will not be paid

You will not receive Long-term Disability benefits if:

- Your disability is related to a pre-existing condition.
- You're on unpaid leave of absence when the disability occurs (not including maternity leave during which you are disabled due to complications of childbirth).
- You're not under the care of a certified specialist for the condition involved where Canada Life considers it appropriate for the severity of the condition.
- You refuse to apply, reapply or appeal decisions on other disability benefits, where Canada Life considers it appropriate. See Deductions from Long-term Disability Benefits.
- You refuse any medical treatment Canada Life or your physician recommends.
- If able, you do not participate in a rehabilitation program or customary and reasonable treatment program that Canada Life recommends or approves.
- You do not participate or cooperate in a required medical or vocational assessment.
- The disability is the result of war, insurrection or voluntary participation in a riot, other than while you're on a business trip for the Bank.
- Substance abuse contributed to your disability and you refuse to participate in a recognized substance withdrawal program or counselling plan that Canada Life or your physician recommends.

When benefits will not be paid continued

- You are incarcerated, confined or imprisoned by authority of law.
- You are outside Canada for more than 30 days and Canada Life did not pre-authorize your trip.
- You are suspended or terminated, or on salary continuation subsequent to being given notice of termination of employment.

If you begin a Long-term Disability leave, you'll be provided with detailed information about your responsibilities and how you can work with Canada Life towards a timely and safe return to health.

What is a pre-existing condition?

If you become disabled in the first year of Long-term Disability coverage from a disease or injury for which you had medical care in the 90 days before your Long-term Disability coverage began, you are not eligible for Long-term Disability Benefits for that pre-existing condition.

But this exclusion does not apply if:

- You have been treatment-free for this pre-existing condition for a period of 90 continuous days within your first year of coverage, or
- You become disabled after one year of continuous Long-term Disability coverage.

Continuation of other benefits

While you're receiving Long-term Disability Benefits, premiums for Life Insurance, Accidental Death & Dismemberment and Critical Illness Insurance will be waived; however, coverage will remain intact. Your other benefits (i.e. Health, Optional Dental and Optional Emergency Out-of-Province/Country Health insurance plan) coverage will continue at the same level as when you started your Long-term Disability leave.

You are responsible for paying the premiums for any other Employee-paid Optional Coverage you choose to continue during your Long-term Disability leave (i.e., Optional Health, Dental and Emergency Out-of-Province/Country Health insurance coverage).

You will automatically receive a Pre-Authorized Debit form from Manulife. You are responsible for submitting your signed Pre-Authorized Debit form to Manulife to authorize your payroll account to be debited for the applicable benefits throughout your leave.

If you do not submit your signed Pre-Authorized Debit form within 31 days, any Optional Health, Dental and Emergency Out-of-Province/Country Health insurance coverage that is not paid for by the credits allotted to you by the Bank will be terminated (you will have at least Bank-paid Core Coverage consisting of Core Health, Core Life and Short-term Disability coverage) and any unused credits will be allocated to your Health Care Spending Account.

If you experience a Work/Life Event while you are on Long-term Disability:

- You may not change your Optional Life insurance, Optional Accidental Death & Dismemberment, Optional Critical Illness insurance or Long-term Disability coverage
- You may decrease, but not increase your Optional Health, Optional Dental or Optional Emergency Out-of-Province/Country Health insurance coverage. Dental Option 3 cannot be decreased if you have not satisfied the two full-plan year lock-in period.

If annual enrolment occurs while you are on Long-term Disability:

- You may not change your Optional Life insurance, Optional Accidental Death & Dismemberment, Optional Critical Illness insurance or Long-term Disability coverage
- You may increase or decrease your Optional Health, Optional Dental or Optional Emergency Out-of-Province/Country Health insurance coverage. Dental Option 3 cannot be decreased if you have not satisfied the two full-plan year lock-in period.

Returning to work from a Long-term Disability leave

The Plan is focused on your recovery and your safe and timely return to health.

Earnings Under a Rehabilitation or Modified Work Program

- While you are on a Rehabilitation or Modified Work Program:
  - You will continue to be on approved Long-term Disability leave;
  - The income you receive is based on your Long-term Disability benefit plus 50% of your part-time Rehabilitation earnings;
  - Your Rehabilitation earnings are the hourly equivalent of your annual salary;
  - The total amount received from the Long-term Disability Plan and Rehabilitation employment cannot exceed 100% of your Benefits Salary;
- Earnings received from an approved rehabilitation program are not used to reduce your Long-term Disability benefit unless your employment earnings plus your Long-term Disability benefit exceeds 100% of your net pre-disability earnings. If it does, your Long-term Disability benefit is reduced by the amount in excess of 100%.

Recurring disabilities

If your disability recurs after you return to work, the following rules apply.

- **For the same or a related disability:** If you have been back at work for less than six months and you go on leave again for the same or a related disability, this leave is considered a continuation of the original Long-term Disability leave and you won't have to satisfy another Long-term Disability waiting period; your Long-term Disability Benefits will begin again at the same benefit level you were previously receiving
- **For a completely different disability:** If you return to work and you start a leave again for an unrelated disability, your absence is considered a new absence; you must apply for Short-term Disability Benefits again and wait another 26 weeks to be eligible for Long-term Disability.

Deductions from Long-term Disability Benefits

Long-term Disability Benefits are reduced if you also receive income from certain other sources. You must notify Canada Life if you receive other income during your disability. There are two types of reductions that the Long-term Disability Plan provides for:

Direct Offset Provision

If you are approved for Long-term Disability Benefits, your Long-term Disability benefit from Canada Life will be directly reduced by the following income:

1. Disability or retirement benefits to which you are entitled on your own behalf under:
   - the Canada or Quebec Pension Plan; or
   - a similar plan in another country which has a reciprocal agreement with Canada or Quebec.
2. Benefits under any Workers' Compensation Act or similar law
3. Employer sponsored Short-term Disability or sick leave benefits
4. Loss of income benefits under an automobile insurance plan, to the extent permitted by law

All-Source Maximum Provision

If your combined Long-term Disability benefit and income listed below exceeds 85% of your net take-home pay (monthly earnings, less deductions for federal and provincial income taxes, C/QPP contributions and federal Employment Insurance premiums), Canada Life will further reduce your Long-term Disability benefit in order to recover the excess. You are required to repay to Canada Life any overpayment resulting from this additional income. Sources of income include:

1. Loss of income benefits available through legislation to which you or another member of your family is entitled on the basis of your disability, except for Canada or Quebec Pension Plan, Employment Insurance benefits and automobile insurance benefits.
2. The wage loss portion of any criminal injury award.
3. Disability benefits under a plan of insurance available through an Association.
4. Employment income, disability benefits, or retirement benefits related to any employment, except for:
   - disability benefits that are prepayments of Life insurance.
   - benefits from retirement plans to which an employer has not contributed.
   - any amount that is related to employment other than with the employer and that was payable for each of the 12 months before a disability period.
   - employer sponsored Short-term Disability or sick leave benefits.
   - income from an approved rehabilitation plan. This income is considered under the offset and rehabilitation incentive provisions.

Life Insurance

What you should know

- With the Bank-paid Core coverage, you are automatically covered for 100% of your Benefits Salary rounded to the next $1,000, up to a maximum of $250,000. The premium the Bank pays is a taxable benefit to you.
- If you die, the benefit pays a tax-free lump sum to your beneficiaries, equal to 100% of your Benefits Salary up to $250,000.

Optional Life Insurance

- You can buy up to nine times your Benefits Salary to a maximum of $1,500,000.
- If your Benefits Salary changes during the Plan year, your coverage level and premium will automatically increase.
- You can buy up to $250,000 for your spouse.
- You must provide Evidence of Insurability for all amounts of Life insurance selected for yourself and your spouse. Evidence of Insurability is not required for Child Life insurance.
- All premiums for Optional Life insurance are paid through payroll deductions.
- Life insurance is provided by Canada Life Assurance Company.

Coverage options

	Optional Employee Life Insurance*	Optional Spousal Life Insurance	Optional Child Life Insurance
Option 1	1x Benefits Salary	$5,000	$5,000
Option 2	2x Benefits Salary	$15,000	$10,000
Option 3	3x Benefits Salary	$30,000	$15,000
Option 4	4x Benefits Salary	$50,000	$20,000
Option 5	5x Benefits Salary	$100,000	
Option 6	6x Benefits Salary	$150,000	
Option 7	7x Benefits Salary	$250,000	
Option 8	8x Benefits Salary		
Option 9	9x Benefits Salary		

*to a maximum of $1,500,000

Eligibility

In addition to the Plan's eligibility rules (see page 7), you and/or your spouse must be under age 80 to be eligible to buy Optional Life insurance coverage.

When coverage ends

In addition to the rules for when the Plan's coverage ends (see page 4), any Optional Life insurance coverage you buy ends when the covered person turns age 80.

Optional Life insurance coverage will not be extended during the period subsequent to notice of termination of employment, except as is required by law.

Naming your beneficiaries

You must name one or more beneficiaries when you first enrol in the Plan. You can name a person or an organization, such as a charity, as a beneficiary. If you don't name a beneficiary, or the person you name is not alive when you die (and there is no contingent or "back up" beneficiary named), the benefit will be paid to your estate.

If you name a minor child as a beneficiary, you can also name a trustee (except if you live in Quebec). An insurer cannot pay a benefit to a child until the child reaches the age of majority in their home province or territory.

It is important to review your beneficiaries annually to make sure your information is up to date. You can change your beneficiaries at any time on the Manulife Plan Member Site by going to Forms > Administration Forms > Name Beneficiaries (online form).

If you live in Quebec

If you live in Quebec and you designate your legal spouse as your beneficiary, you may not change this designation, unless you specify that you want it to be revocable. You may not change a beneficiary previously designated as irrevocable without the consent of the beneficiary.

Advance payment benefit

If you, or your covered spouse or child, are diagnosed with a terminal illness and are expected to die within 24 months, you may apply to receive an advance payment of up to 50% of the Life insurance benefit. Upon death, the balance of the benefit will be paid.

You may be eligible for an advanced Life benefit if:

- you have not named an irrevocable beneficiary;
- you submit a written request;
- the prognosis of the illness is terminal and the insured person is not expected to live longer than 24 months from the date of the application;
- the attending physician provides sufficient medical evidence, including the diagnosis and prognosis, to allow a thorough assessment of his life expectancy; and
- Scotiabank authorizes the request for the payment of this benefit.

Suicide limitation

If a covered person commits suicide within two years after any Optional Life insurance coverage you buy takes effect or increases, the benefit payable for the portion of that insurance that has been in force for less than two years will be limited to:

- $10,000 for the employee, and
- The premiums paid for the spouse.

This limitation doesn't apply to any Optional Life insurance coverage you bought to cover your child.

Life Insurance Conversion Privilege

You or your spouse is entitled to obtain an individual Life insurance policy without Evidence of Insurability if the following conditions are met:

1. All or part of the Life insurance terminates on or before the 70th birthday.
2. Application for the individual policy is made in writing and the first premium is paid within 45 days after the insurance terminates.

The conversion privilege is not available if the insurance terminates because of age.

The conversion privilege is not available to a spouse for whom insurance terminates because:

1. Your spouse ceases to be insurable
2. You choose to insure a different spouse.

The amount of the individual policy will not exceed the lesser of:

1. the amount of terminated insurance less the amount of any group term Life insurance for which the person becomes eligible within the 45 days allowed for conversion; and
2. $200,000.

The individual policy takes effect at the end of the 45 days allowed for conversion. If you or your spouse die within the 45 days allowed for conversion, the lesser of the following amounts is payable as if the death occurred while the insurance was still in force:

1. the total amount of terminated insurance and
2. $200,000

To initiate the conversion process please contact Manulife directly at 1-800-268-6195.

Accidental Death and Dismemberment Insurance

What you should know

- Optional Accidental Death and Dismemberment coverage pays a tax-free lump sum in the event of accidental death or serious injuries. See the table below to learn how benefits are paid.
- The level of Accidental Death and Dismemberment benefits depends on the severity of the injury. There are coverage restrictions for certain situations. See the "When benefits will not be paid" section on page 40 for more information.
- Coverage for you, your spouse and/or children are paid through payroll deductions.
- Accidental Death and Dismemberment coverage is purchased in increments of $10,000 from $20,000 to a maximum of $1,000,000.
- Evidence of Insurability is not required for Accidental Death and Dismemberment insurance.
- Accidental Death and Dismemberment insurance is provided by SSQ Life Insurance Company Inc.

Coverage options

Optional Accidental Death and Dismemberment insurance gives you the opportunity to provide additional financial security should an accidental injury or death occur in your family. Accidental Death and Dismemberment provides 24-hour, year-round coverage. You can select a principal sum of $20,000 to $1,000,000, in increments of $10,000. For employees age 70 and over, the maximum benefit amount is $250,000.

You can also cover your spouse and/or dependent children. You are the automatic beneficiary for any Accidental Death and Dismemberment benefits payable due to the accidental death or covered injury of your spouse or dependent children.

If you select coverage for you, your spouse and/or dependent children under Optional Accidental Death and Dismemberment insurance, you will be insured for the following amounts.

- Your spouse and children: The benefit payable for your spouse will be 60% of your principal sum (for Optional Accidental Death and Dismemberment insurance), but only up to a maximum benefit amount of $300,000 (so your spouse's maximum benefit is $180,000); and the maximum benefit payable for each child is 15% of your principal sum up to a maximum benefit amount of $100,000 (a child's maximum benefit is $15,000).
- Your children only (in the event there is no spouse covered): The benefit payable for each child will be 20% of your principal sum (for Optional Accidental Death and Dismemberment insurance) up to a maximum benefit amount of $100,000 (a child's maximum benefit is $20,000).

When benefits will be paid

The Schedule of Benefits provides the Maximum benefits payable to the insured as follows:

Loss of	Benefit paid
Life	1¼ of your principal sum
The entire sight of both eyes	Your principal sum
Speech and hearing in both ears	Your principal sum
One hand and the entire sight of one eye	Your principal sum
One foot and the entire sight of one eye	Your principal sum
The entire sight of one eye	Your principal sum
Speech	Your principal sum
Hearing in both ears	Your principal sum
Hearing in one ear	½ of your principal sum
All toes of one foot	⅓ of your principal sum

Loss or loss of use of	Benefit paid
Both arms	Your principal sum
Both legs	Your principal sum
Both hands	Your principal sum
Both feet	Your principal sum
One hand and one foot	Your principal sum
One arm	Your principal sum
One leg	Your principal sum
One hand	Your principal sum
One foot	Your principal sum
The thumb and index finger or at least four fingers of one hand	⅓ of your principal sum

Paralysis of	Benefit paid
Both upper and lower limbs (quadriplegia)	2 x your principal sum
Both lower limbs (paraplegia)	2 x your principal sum
The upper and lower limbs of one side of the body (hemiplegia)	2 x your principal sum

The maximum benefit paid for any combination of injuries is 2x your principal sum. But if a covered person suffers an injury that results in paralysis, and then dies within 90 days of the accident, only the loss of Life benefits will be paid.

What is your principal sum?

Your principal sum is the amount of Optional Accidental Death and Dismemberment coverage that you choose to purchase. Accidental Death and Dismemberment insurance pays a specific percentage of your principal sum depending on the severity of the injury.

Additional Accidental Death and Dismemberment benefits

Surgical Reattachment Benefit

- If an Injury results in the complete severance of the limb or appendage or part of a limb or appendage, and if the severed limb, appendage or part is then surgically reattached to the covered person within 365 days after the date of the Accident resulting in the injury, then the benefit will be paid to the Insured Person as follows:

  1. Whether or not the Insured Person regains use of the severed limb, appendage or part, the Insurer will pay a benefit equal to 50% of the benefit that would have been payable under the Schedule of Benefits for the loss of the limb, appendage or part, if the surgical reattachment had not been performed.
  2. If the reattachment of the severed limb, appendage or part is unsuccessful within 365 days after the date of the Accident and, you or your covered dependent suffers a total, irrecoverable and permanent Loss of Use of the reattached limb, appendage or part, the Insurer will pay a benefit as provided under the Schedule of Benefits for Loss of Use of the limb, appendage or part, less any amount(s) paid or payable under the "Surgical Reattachment Benefit" shown above.
  3. If, the reattachment of the severed limb, appendage or part fails within 365 days after the date of the Accident and the limb, appendage or part must be amputated, the Insurer will pay a benefit as provided under the Schedule of Benefits for the loss of such limb, appendage or part less any amount(s) paid or payable under "Surgical Reattachment Benefit", under items (1) and (2) listed above.

When benefits will be paid continued

- Any payable benefit will not exceed the Principal Sum for an Insured Person as the result of any one accident.

Repatriation Benefit

- If you, or a covered dependent suffers Loss of Life as a result of an Injury that occurred more than 50 kilometres from your Normal Place of Residence, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay the reasonable and necessary expenses incurred for the transportation of the body. This includes transportation of the deceased to a resting place in proximity to the Normal Place of Residence (including but not limited to a funeral home or the place of interment), and charges for the preparation of the body for transportation, not to exceed the aggregate amount of $25,000 for all such expenses paid as a result of the Accident.
- The benefit payable under this section will be payable to the person who actually incurred the expenses.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above.

Education Benefit

- In the event you or your insured spouse suffers Loss of Life resulting from an Injury, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay the reasonable and necessary tuition fees for any dependent child who, on the date of or within the following 365 days of the Insured Person's death, is enrolled or enrols as a full-time student in any Institution for Higher Learning, up to the lesser of the following amounts:

  (a) 5% of your Principal sum; or

  (b) $5,000, for each year (up to five consecutive years) per child during which your child remains enrolled as a full-time student in any Institution for Higher Learning.
- The total maximum payable will not exceed $5,000 per year per dependent child.
- The benefit is paid each year upon receipt of proof, satisfactory to the Insurer, that the dependent child is enrolled as a full-time student in any Institution for Higher Learning. Payment is not made for expenses incurred prior to the Loss of Life of the Insured Person, for room and board, books or other living, travelling or clothing expenses.
- The benefit will be payable to the person who actually incurred the expenses.

  The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above.

Day-Care Benefit

- In the event you or your insured spouse suffers Loss of Life resulting from an Injury, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay the reasonable and necessary expenses incurred for the Day-Care Centre attendance for any dependent child under 13 years of age at the date of your death, who on the date of or within the following 365 days after your death, is enrolled or enrolls in a Day-Care Centre, to the lesser of the following amounts:

  (a) 5% of your Principal Sum or

  (b) $5,000, for each year (up to 5 consecutive years) per dependent child during which such dependent child remains enrolled in a Day-Care Centre.
- The total maximum payable under this section will not exceed $5,000 per year per dependent child.
- The amount is paid each year upon receipt of satisfactory proof that the dependent child is enrolled in a Day-Care Centre, but payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.
- The benefit will be payable to the person who actually incurred the expenses.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above.
- If none of the Insured Person's dependent children satisfy the above requirements or the requirements as shown under "Education Benefit", the Insurer will pay to your beneficiary the lesser of the following amounts:

  (a) 5% of the deceased Insured Person's Principal sum; or

  (b) $2,500 under only one of the policies issued by the Insurer.

Rehabilitation Benefit

- In the event you suffer a Specific Loss resulting from an Injury, and the benefit becomes payable under the Schedule of Benefits; and the Injury requires that you participate in a rehabilitation program; the Insurer will pay the reasonable and necessary expenses incurred for such program within 3 years after the date of loss.
- Payment is not made for room and board or other ordinary living, travelling or clothing expenses.
- Payment by the Insurer for the total of all expenses that you incurred under this section will not exceed $15,000 as the result of any one Accident.

When benefits will be paid continued

- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued to you or your beneficiary, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above.

Workplace Modification and Accommodation Benefit

- In the event you suffer a Specific Loss resulting from an Injury, and it becomes payable under the Schedule of Benefits; and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active work with Scotiabank, the Insurer will pay the reasonable and necessary expenses actually incurred by Scotiabank for such equipment and/or modification provided:

  (1) Scotiabank agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs; and

  (2) Scotiabank acknowledges in writing that the performance of the essential duties of your job would be compromised in the absence of such modification or accommodation; and

  (3) The proposed special adaptive equipment and/or workplace modification have prior written approval by the Insurer.
- The Insurer has the right to request that you be examined by a professional of its choice to evaluate the appropriateness of the proposed modifications and/or equipment.
- Scotiabank will pay the amount under this section once you have returned to active work and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if Scotiabank does not incur any cost in providing the special adaptive equipment and/or the workplace modification.
- Payment by the Insurer for the total of all expenses incurred by Scotiabank will not exceed $5,000 because of any one Accident.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above

Occupational Training Benefit

- In the event you suffer Loss of Life resulting from an Injury, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay the reasonable and necessary expenses actually incurred by your spouse who engages in a formal occupational training program within 3 years after the date of your death in order to become specifically qualified for active employment in an occupation for which they would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.
- Payment for the total of all expenses incurred by your spouse will not exceed $15,000.
- The benefit will be paid to the person who actually incurred the expenses.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above

Enhanced Child Benefit

- In the event an insured Dependent Child suffers a Specific Loss resulting from an Injury and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay quadruple the applicable benefit with exception of Loss of Life.
- This benefit is not applicable if the insured Dependent Child dies because of the Injury or from any cause within 90 days after the date of the Accident.

Permanent Total Disability Indemnity (Only applies to covered employees)

- If you suffer from an Injury resulting in Total Disability within 365 days after the date of the Accident, the Insurer will pay the Principal Sum, less any amount paid or payable as the result of the same Accident under the Schedule of Benefits. The Total Disability must continue over a period of 12 consecutive months following Commencement of Total Disability and is permanent at the end of this period.

Family Transportation Benefit

- In the event an Insured Person suffers a Specific Loss resulting from an Injury, and the benefits becomes payable under the Schedule of Benefits, and the Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by one Immediate Family Member or family representative for round-trip Transportation to the bedside of the Insured Person by the most direct route from the normal place of residence of the Immediate Family Member or family representative, in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route if the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.
- The Insurer will not pay any benefit mentioned above unless the Insured Person is admitted as an inpatient in a Hospital located more than 50 kilometres from his normal place of residence.

When benefits will be paid continued

- Reimbursement of Transportation expenses is limited to the cost of a single return trip to the bedside of the Insured Person while in Hospital. More than one form of transportation may be used if necessary, but the amount paid will be limited to the Fare(s) reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of 35 cents ($0.35) per kilometre travelled for such return trip.
- The total maximum amount payable will not exceed $25,000 because of any one Accident.
- The benefit will be payable to the person who actually incurred the expenses.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above

Identification Benefit

- In the event an Insured Person suffer a Loss of Life resulting from an Injury; and the benefit becomes payable under the Schedule of Benefits; and the police or similar governmental authority requires identification of the Insured Person's body, the Insurer will pay the reasonable and necessary expenses actually incurred by one Immediate Family Member or family representative for round-trip Transportation to the location of the Insured Person's body by the most direct route from the normal place of residence of the Immediate Family Member or family representative. in the vicinity, and return to the normal place of residence of such or family representative by the most direct route, if, at the time of death, the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.
- The Insurer will not pay any benefit unless the Insured Person's body is located more than fifty 50 kilometres from the Insured Person's normal place of residence.
- Reimbursement of Transportation expenses is limited to the cost of a single return trip to identify the deceased Insured Person. More than one form of transportation may be used if necessary, but the amount paid will be limited to the Fare(s) reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of transportation expenses will be limited to a maximum of 35 cents ($0.35) per kilometres travelled for such return trip.
- The total maximum amount payable will not exceed $25,000 because of any one Accident.
- The benefit will be payable to the person who actually incurred the expenses.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above

Common Disaster Benefit

- In the event you and your insured Spouse both suffer Loss of Life and the benefit becomes payable under the Schedule of Benefits as a result of a Common Accident, the benefit for such Loss of Life applicable to your insured spouse will be increased up to your Principal Sum amount. Both Losses of Life must occur within 90 days of the Accident.
- Note: This benefit is not payable in the event both you and your Insured spouse are employed by Scotiabank and both of you have purchased the Employee plus one Dependent or Employee plus two or more Dependents plan under Optional Accidental Death & Dismemberment insurance.

Seat Belt Benefit

- In the event an Insured Person suffers a Specific Loss resulting from an Injury and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay an additional benefit equal to 10% of the applicable benefit payable under the Schedule of Benefits, subject to a maximum of $50,000, if at the time of the Accident, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt. At the time of the Accident, the driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Motorized Vehicle and neither be Intoxicated nor Under the Influence of Drugs.
- Proof of Seat Belt use to the satisfaction of the Insurer must be provided as part of the written proof of loss.

Home Alteration and/or Vehicle Modification Benefit

- In the event an Insured Person suffers a Specific Loss listed below resulting from an Injury, and the benefit becomes payable under the Schedule of Benefits and the Insured Person requires the use of a wheelchair in order to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person for home alteration and/or vehicle modification, within 3 years following the date of Loss:

When benefits will be paid continued

(1) Loss of both feet or legs; or

(2) Loss of Use of both feet or legs; or

(3) Quadriplegia, Paraplegia or Hemiplegia,

- To be covered under this section, the alteration or modification must enable the Insured Person to access their residence and/or their vehicle in a wheelchair and must be approved, where required by law, by licensing authorities.
- The total maximum amount payable by the Insurer will not exceed $15,000 because of any one Accident.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above

Hospital Indemnity

- In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the Schedule of Benefits; and the Injury requires the Insured Person to stay in a Hospital and under the Regular Care and Attendance of a Physician for at least four consecutive days, the Insurer will pay a Daily Indemnity provided such Period of Hospitalization is necessary for the treatment of this Injury. The Daily Indemnity will be paid from the first Day of Hospitalization, to a maximum of 365 days per Accident.
- However anything contained to the contrary in the Policy, a Period of Hospitalization which becomes necessary for the treatment of an Injury which resulted in a Specific Loss will be covered in accordance with the terms of this section, provided such Period of Hospitalization commences:

  (1) within 365 days after the date of the Accident causing such Injury; and

  (2) while this Insured Person's individual coverage under the Policy is in force.
- Such Daily Indemnity will be calculated as payable from the first Day of Hospitalization provided the Insured Person is hospitalized for at least 4 consecutive days.
- Only one Period of Hospitalization will be payable for all Injuries sustained by the Insured Person as the result of one Accident.

Cosmetic Disfigurement Benefit

- In the event an Insured Person suffers a Burn resulting from an Injury, the Insurer will pay a benefit based on the Cosmetic Burn Schedule below, by multiplying the applicable Area Classification Factor by the percentage of body surface actually burned, subject to the Maximum Allowable Percentage for Body Surface Burned times the Principal Sum.

Cosmetic Burn Benefit Schedule

Body Part	Area Classification Factor	Maximum Allowable Percentage for Body Surface Burned
Face, neck, head	11	9%
Hand and forearm (right)	5	4.5%
Hand and forearm (left)	5	4.5%
Upper arm (right)	3	4.5%
Upper arm (left)	3	4.5%
Torso (front)	2	18%
Torso (back)	2	18%
Thigh (right)	1	9%
Thigh (left)	1	9%
Lower leg - below knee (right)	3	9%
Lower leg - below knee (left)	3	9%

- The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Benefit Schedule, is based on 100% of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.
- If an Insured Person suffers a Burn or Burns to more than one body part because of any one Accident, benefits payable for all such Burn or Burns will not exceed 100% of the Insured Person's Principal sum.

Escalation Benefit

- In the event an Insured Person suffers a Specific Loss resulting from an Injury and the benefit becomes payable under any of the following sections in the Schedule of Benefits, "Permanent Total Disability Indemnity", "Comatose Benefit" or "Brain Damage Benefit", the Insurer will pay 1% of such benefit for each year your individual coverage has remained continuously in force under the Policy without interruption, subject to an overall maximum of $75,000.
- The Principal Sum applicable will be the amount stated on your most recent record of the Canadian Benefits Plan, on file with Scotiabank and on the date of the accident.
- The number of years your individual coverage remained in force will be counted as follows:

  1. With respect to Insured employees who have been continuously insured during the period April 1, 1998 to April 1, 2013 issued by the Insurer, one year will be counted on the first anniversary date of such Insured employees' Effective Date of Individual Coverage under the above-mentioned policies and one year will be added on each subsequent anniversary date thereafter;

When benefits will be paid continued

2. With respect to an Insured employee who becomes insured on the effective date of this benefit, one year will be counted on the first anniversary date of this benefit and one year will be added on each such subsequent anniversary date thereafter;
3. With respect to an Insured employee who becomes insured after the effective date of this benefit, one year will be counted on the first anniversary date of an Insured Employee's insurance under this Policy and one year will be added on each such subsequent anniversary date thereafter.

- An Insured Person who discontinues their coverage and subsequently re-applies for coverage will be considered as a person becoming insured for the first time in the year they re-apply for coverage.

Bereavement Benefit

- In the event an Insured Person suffers a Loss of Life resulting from Injury, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay the reasonable and necessary expenses associated with grief counseling incurred within 365 days after the date of the Accident resulting in such loss, and provided by a Professional Counselor for:
  - your insured Spouse and/or your insured Dependent Children, in the event that you are the Insured Person who suffers a Loss of Life; or
  - you and/or your insured Dependent Children, in the event that your insured spouse is the Insured Person who suffers a Loss of Life; or
  - you and/or your insured spouse, in the event that your insured dependent child is the Insured Person who suffers a Loss of Life.
- The Insurer will pay these expenses for up to a maximum of 6 grief-counseling sessions subject to an overall maximum of $2,500 in relation to the death of the Insured Person. This benefit will not pay for any grief counseling provided by a person who would not ordinarily charge a service fee.
- The benefit will be payable to the person who actually incurred the expenses.
- The benefit under this section will be paid in excess over any other insurance or benefit plans only for the amount which has not been covered after all other insurance or benefit plans or other form of reimbursement have been exhausted, provided the amount is equal to or less than the reasonable and necessary charge.

Funeral Expense Benefit

- In the event an Insured Person suffers a Loss of Life resulting from Injury, and benefit for such a loss becomes payable under the Schedule of Benefits, the Insurer will pay the reasonable and necessary expenses actually incurred at the time of the Insured Person's death for the services and/or materials provided by a mortician, undertaker, crematorium or funeral home that are related to the burial or cremation of a deceased Insured Person, as well as charges for the purchase of a burial plot, gravesite or mausoleum for the interment of the remains of the Insured Person, including any markers or monuments. The aggregate amount payable shall not exceed the amount of $5,000, and the Insurer shall deduct from the amount payable any expenses incurred for preparation of the remains for travel paid or payable under "Repatriation Benefit".
- The benefit will be payable to the person who actually incurred the expenses.
- The amount payable will be coordinated with any amount paid by an identical or similar benefit provided under any other policies issued, such that the total combined amount payable under all the policies will not exceed the maximum amount stated above

Psychological Therapy Benefit

- In the event an Insured Person suffers a Specific Loss resulting from an Injury; and the benefit for such a loss becomes payable under the Schedule of Benefits; and such Injury requires the Insured Person to undergo psychological therapy, the Insurer will pay a benefit equivalent to the reasonable and necessary expenses actually incurred within 365 days after the date of the Accident for psychological therapy provided by a Professional Counsellor. The Insurer will pay up to a maximum of 12 counselling sessions to an overall maximum of $5,000 per any one Accident. This benefit will not pay for any counselling provided by persons who would not ordinarily charge a fee for their services.
- The above benefit will be paid to the person who actually incurred the expenses.
- Benefits under this section will be paid in excess over any other insurance or benefit plans only for the amount which has not been covered after all other insurance or benefit plans or other form of reimbursement have been exhausted, provided the amount is equal to or less than the reasonable and necessary charge.

Assault Benefit

- In the event an Insured Person suffers a Specific Loss resulting from an Injury caused by an Assault on premises owned or rented by Scotiabank or if the Assault occurred while the Insured Person was Travelling on Company Business, and the benefit for such loss becomes payable under the Schedule of Benefits, the Insurer will pay an additional benefit equal to 10% of the applicable benefit payable under that section, subject to a maximum of $25,000.

When benefits will be paid continued

- However, no benefit will be payable if the assault was the act of another Scotiabank employee or an Immediate Family Member of the Insured Person or a member of the Insured Person's household.

Carjacking Benefit

- In the event an Insured Person suffers a Specific Loss resulting from an Injury that occurs during a carjacking of an automobile that the Insured Person was operating, getting into or out of, or riding as a passenger, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay an additional amount equal to 10% of the applicable amount payable under the Schedule of Benefits, subject to a maximum of $10,000.
- Verification of the carjacking must be made part of an official police report within 24-hours of the carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24-hours of the carjacking, or as soon as reasonably possible, and the Insurer must receive a copy of the relevant police report or certification in order for any benefit to become payable under this section.

Public Transportation Benefit

- In the event an Insured Person suffers Loss of Life resulting from an Injury, and the benefit becomes payable under the Schedule of Benefits, the Insurer will pay an additional benefit equal to 100% of the payable benefit if at the time of the Accident the Insured Person was riding as a passenger in a regularly scheduled public land, air or water transportation licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

Comatose Benefit

- In the event a Physician determines that an Insured Person has become Comatose as a result of an Injury, the Insurer will pay a benefit equal to the amount of the Principal Sum less any other amount paid or payable under the Schedule of Benefits as a result of the same Accident, provided:
  1. The Insured Person becomes Comatose within 365 days after the date of the Accident; and
  2. The Insured Person has been Comatose for at least 6 consecutive months.

Aircraft Coverage

- Insurance includes coverage when loss results from Injury sustained while, and as a result, of the Insured Person:
  (a) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot's license of a rating authorizing him to pilot such aircraft.
  (b) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.
  (c) boarding or alighting from or being struck by any aircraft.

Exposure and Disappearance Coverage

- In the event an Insured Person undergoes unavoidable exposure to natural elements and, as a direct result, suffers a Specific Loss for which benefits would have been payable under the Schedule of Benefits if it had been caused by an Accident, the Insurer will pay the amount specified for the same loss as in the Schedule of Benefits.
- In the event an Insured Person is not found within 1 year following the date of the disappearance, sinking, or wrecking of the conveyance in which the Insured Person was riding, and under such circumstances as would otherwise be covered under the Schedule of Benefits, it will be presumed that the Insured Person suffered Loss of Life resulting from an Injury at the time of the disappearance, sinking or wrecking.

Brain Damage Benefit

- In the event an Insured Person suffers Brain Damage because of an Injury, the Insurer will pay the Principal sum, less any other amount paid or payable in the Schedule of Benefits as the result of the same Accident, provided:
  1. The Insured Person incurs Brain Damage within 120 days from the date of the Accident; and
  2. The Insured Person is hospitalized as a result of Brain Damage at least seven of the first 120 days of the Injury; and
  3. A Physician determines, and the Insurer is satisfied, that the Insured Person has evidence of Brain Damage for at least 6 consecutive months.

When benefits will not be paid

Benefits are not paid for injuries that result from any of the following causes or situations:

- Self-inflicted injuries, suicide or attempted suicide
- Declared or undeclared war, whether or not you were participating in it, if:
  - You were not on a business trip for the Bank at the time
  - You were on a business trip for the Bank at the time in Canada or the United States
- Perpetration of acts of terrorism
- Participation in civil commotion, riot, insurrection or armed conflict
- Service in the armed forces of any country, as a combatant or non-combatant
- You were riding in any vehicle or device for aerial navigation, other than under the aircraft coverage benefit, or
- Medical treatment or surgery unless it was needed because of an accident

Naming your beneficiaries

You must name one or more beneficiaries when you first enrol in the plan. You can name a person or an organization, such as a charity, as a beneficiary. If you don't name a beneficiary, or the person you name is not alive when you die (and there is no contingent or "back up" beneficiary named), the benefit will be paid to your estate.

If you name a minor child as a beneficiary, you can also name a trustee (except if you live in Quebec). An insurer cannot pay a benefit to a child until the child reaches the age of majority in their home province or territory.

It is important to review your beneficiaries annually to make sure your information is up to date. You can change your beneficiaries at any time on the Manulife Plan Member Site by going to Forms > Administration Forms > Name Beneficiaries (online form).

If you live in Quebec

If you live in Quebec and you designate your legal spouse as your beneficiary, you may not change this designation, unless you specify that you want it to be revocable. You may not change a beneficiary previously designated as irrevocable without the consent of the beneficiary.

Accidental Death and Dismemberment Conversion Privilege

In the event your coverage is terminated as a result of any of the following reasons, you may obtain an individual accident policy by providing a written application to the Insurer within 45 days of:

- termination of your employment; or
- your ceasing to be eligible for this benefit; or
- the period where you are totally disabled comes to an end but you did not return to work for Scotiabank.

Once the application is received, an individual accident policy will be sent to you and your spouse, provided your spouse was insured under this benefit prior to your termination of insurance.

Note: a conversion will not be possible if the policy is terminated at the time of the application.

The benefits provided will be set out in the Schedule of Benefits available from the Insurer at the time of conversion. The amount of insurance that may be converted will not exceed the amount of insurance in effect on the date of termination, or a total aggregate of $1,000,000 or $250,000 if you at age 70 or older for all conversions with the Insurer. The amount of insurance for the Insured spouse will be 60% of yours, subject to a maximum Principal Sum of $300,000.

To initiate the conversion process please contact Manulife directly at 1-800-268-6195. See me@scotiabank > *Ask HR* for additional information.

Emergency Out-of-Province/Country Health Insurance Coverage

What you should know

- Optional Emergency Out-of-Province/Country Health insurance coverage pays for health expenses and additional travel assistance benefits, for up to 45 days when you are away from your home province or territory.
- You can buy Optional Emergency Out-of-Province/Country Health insurance using credits first, followed by payroll deductions if you use all your credits.
- The Bank has separate Emergency Out-of-Province/Country Health insurance coverage for Scotiabankers who travel on behalf of the Bank for business.
- If you are travelling on Bank business you and your accompanying spouse are automatically covered under the Bank's plan for up to 60 days of travel.
- Emergency Out-of-Province/Country Health insurance coverage is provided by SSQ, Life Insurance Company Inc. (SSQ). AXA Assistance Canada Inc. (AXA) provides travel assistance benefits.
- Optional Emergency Out-of-Province/Country Health insurance coverage requires that you and your dependents also have provincial health care coverage in effect as the coverage available in the Canadian Benefits Plan supplements, and does not replace, any government sponsored plans.
- If you are travelling outside of Canada, the Emergency Out-of-Province/Country Health insurance provided by SSQ offers full coverage for eligible health expenses except where the Government of Canada has issued an advisory to avoid all travel.

Eligibility

In addition to the Plan's eligibility rules (see page 7), you or your dependents must be covered under your provincial or territorial health plan to be eligible for Emergency Out-of-Province/Country Health insurance coverage. If your dependent child is studying outside of Canada, they will not be covered under this benefit.

In addition to the Plan's eligibility rules (see page 7), your spouse must be under age 80 to be eligible for Emergency Out-of-Province/Country Health insurance coverage.

Coverage levels

Benefit	Maximum per incident
Medical expenses and services	$1 million
Evacuation	$50,000
Family transportation and accommodation	$10,000
Hotel convalescence	$1,000
Rental expense	$200
Repatriation	$15,000
Return of vehicle	$500

What is covered

To be covered, expenses must be incurred:

- On an emergency basis
- Outside the covered person's home province or territory, and
- In excess of expenses payable under any individual, group or government-sponsored hospital or medical insurance plan

Eligible Medical expenses and services

- Hospital charges for room and board, including semi-private accommodation for up to 12 months
- Hospital charges for out-patient services, when medically required
- Services provided by a nurse, if prescribed by a physician ($5,000 maximum per incident)
- Prescription drugs, prescribed by a physician or legally qualified dentist and dispensed by a registered pharmacist or physician (limited to a 30-day supply)
- Licensed physiotherapist, if prescribed by a physician ($1,000 per incident), if the physiotherapist doesn't normally live with the covered person and is not an immediate family member
- Licensed ground ambulance service or for transportation to the nearest hospital that is equipped to provide the necessary treatment ($1,000 per incident), when recommended by a physician, and
- Expenses for medical services, such as:
  - Blood plasma, whole blood or oxygen
  - X-rays and laboratory examinations needed for diagnostic purposes
  - Renting or buying casts, cervical collars, crutches, trusses, splints and braces (except dental braces and splints), and
  - Renting a wheelchair, iron lung and other durable medical equipment for temporary therapeutic treatment ($5,000 per incident)
- Expenses for medical care and treatment or surgical procedure performed by a physician
- Expenses for the services of a licensed anesthetist, when recommended by a physician
- Expenses for the services of a licensed chiropractor, chiropodist or podiatrist who does not live with the covered person, and

What to do in an emergency

An emergency is an event that is unexpected and not pre-planned. If you have a medical, travel or personal emergency when you're away from home, you must contact AXA within 48 hours, or when reasonably possible. If you don't contact AXA within 48 hours of admission to a hospital, reimbursement for expenses may be reduced.

You can call AXA 24 hours a day, 365 days a year. You'll find your policy number and the telephone number to call on your benefits card. You must give AXA the following information when you call:

- The name of the person calling, telephone number and relationship to the covered person
- The covered person's name, location, member number and policy number on your benefits card
- The condition of the covered person and the nature of the emergency, and
- The names, locations and telephone numbers of the hospital and physician treating the covered person

What is covered continued

is not an immediate family member ($300 per practitioner, per incident, and only when recommended by a physician). Expenses for diagnostic X-rays and laboratory tests ordered by these practitioners are covered, up to one X-ray per practitioner, per incident, and

- Accidental dental treatment due to a force or blow external to the mouth, up to $2,000 per accident

Evacuation Benefit

You're covered for up to $50,000 per incident. This includes:

- Transportation by any conveyance (other than ground ambulance) licensed to carry passengers for hire, including air ambulance, to the nearest hospital that is equipped to provide the required treatment (or medical facility or doctor's clinic, when warranted), provided the evacuation is recommended by the attending physician and approved by the insurance provider SSQ.
- Transportation to the Insured Person's home province by any conveyance (other than ground ambulance) licensed to carry passengers for hire, including air ambulance provided the evacuation is recommended by the attending Physician and approved by the Insurer and the attending Physician certifies in writing that the Insured Person's medical condition after receiving treatment (including diagnostic testing) warrants the return to their home province for further treatment or to recover.
- Transportation to the Insured Person's home province in the event of being admitted as an inpatient to a hospital and under the Regular Care and Attendance of a physician, therefore preventing a return home on the original scheduled return flight, provided the return ticket is non-changeable and non-refundable.
- Roundtrip airfare, accommodation and board for a medical attendant or one family member, up to $5,000

If a patient needs to be transferred

After consulting with the attending physician, AXA has the right to transfer the patient to another hospital or to his or her home province or territory for necessary treatment. If you refuse, AXA isn't liable for any additional expenses for treatment related to the condition incurred after the proposed transfer date.

Family Transportation and Accommodation Benefit

If a covered person dies, or is kept as an in-patient under the regular care and attendance of a physician for at least four consecutive days, the person is covered for up to $10,000 (per incident) for the following reasonable and necessary expenses:

- One-way fare for a covered person or a travelling companion who was prevented from returning to their home province or territory on the day originally scheduled because they remained with the covered person during hospitalization. This applies only if the return fare is non-changeable and non-refundable. This benefit includes board, accommodation and transportation home.
- Board and accommodation for a family member or representative, and one return fare for transportation home by the most direct route. If the covered person was travelling on their own when they became hospitalized, reimbursement is limited to 75% of the cost of the fare for the family member or family representative. If transportation is in a motorized vehicle, other than those licensed for transportation of passengers for hire, then reimbursement will be limited to $0.35 per kilometre.

Board and accommodation is paid at $50 per day, for a maximum of:

- 20 consecutive days if the covered person is confined to a hospital, whether or not they die, or
- Five consecutive days, if the covered person dies.

Hotel Convalescence Benefit

If a covered person can't continue travelling due to an illness or injury (as certified in writing by a physician) after being released from a hospital stay of seven or more days, SSQ will pay reasonable and necessary expenses for board and accommodation, up to $1,000 per incident.

Rental Expenses Benefit

If a covered person is kept as an in-patient under the regular care and attendance of a physician, SSQ will pay reasonable expenses for renting a telephone or television, up to $200 per incident.

Repatriation Benefit

The repatriation benefit provides up to $15,000 of reasonable and necessary expenses for transporting a covered person's body to the first resting place (e.g., funeral home) near their home if they die more than 50 kilometres away from home. This includes preparing the body for transportation.

Return of Vehicle Benefit

If a covered person becomes disabled (as certified in writing by a physician) and can't continue a trip driving their motorized vehicle, SSQ will pay reasonable and necessary expenses (up to $500 per incident) for a company to return the vehicle to the covered person's home, or to the rental agency (if applicable).

When coverage for a trip begins and ends

Coverage for a trip begins when a covered person crosses the border of their home province or territory. If travelling by aircraft, coverage begins when the aircraft takes off.

Coverage for a trip ends on the earliest of these events:

- A covered person crosses the border of their home province or territory when returning from a trip
- If travelling by aircraft, when the aircraft lands in the covered person's home province or territory, and
- 45 days from the date of departure from the covered person's home province or territory

What is not covered

You're not eligible for benefit payment or reimbursement for expenses that result from any of the following:

- Suicide or intentionally self-inflicted injuries
- Declared or undeclared war, whether or not the covered person was participating in it, if:
  - Not on a business trip for the Bank
  - On a business trip for the Bank in Canada or the United States
- Perpetration of acts of terrorism
- Participation in civil commotion, riot, insurrection or armed conflict
- Service in the armed forces of any country, as a combatant or non-combatant
- Pregnancy or childbirth, except if complications arise, which will be treated as any other illness
- A trip taken to get medical treatment, assessment or consultation
- Participation in any professional athletics
- Participation in acrobatic or stunt flying, mountaineering, hang-gliding, scuba diving or any racing or speed contests, or
- Pre-existing medical condition that has deteriorated, has to be treated or investigated, or for which any type or dosage of medication has changed in the three-month period before the covered person's trip departure date
- Expenses incurred outside of Canada where the Government of Canada has issued an advisory to avoid all travel.

The following supplies, services or costs are not covered:

- Expenses covered by any government hospital, medical, dental or health care insurance plan, whether payable or not
- Expenses for which insurance is prohibited by law
- Medical examinations for the use of a third party, cosmetic surgery and dental services other than those required as a result of an accident
- Experimental drugs not approved by a federal program providing special access to health products, contraceptives of any type or form and patent medicines
- Experimental medical treatments
- Services that wouldn't usually be charged for if there was no insurance coverage
- Expenses incurred for necessary treatment or surgery that medically could be delayed until the covered person has returned to their home province or territory
- Expenses for treatment or surgery that the covered person chooses to have performed outside their home province or territory, after an emergency treatment or diagnosis of a medical condition, which (on medical evidence) would allow them to return to their home province or territory before receiving the treatment or surgery, and
- Medical expenses for services, treatment or prescription drugs provided regularly in the covered person's home province or territory before and during the trip

Travel assistance benefits

AXA also provides the following services to assist covered persons while travelling or away from home:

- Referrals to physicians and health facilities
- Sending, if local laws permit, replacement medication if lost, stolen or finished
- Medical monitoring and evaluation during treatment and ongoing updates to family and/or employer
- Arrangements for medical evacuation to the nearest facility capable of providing the required care
- Special assistance on medically supervised emergency transportation
- Handling arrangements if the covered person dies
- Sending of emergency messages between the covered person and his or her family and/or employer
- Help replacing travel documents, like passports and credit cards while travelling
- Sharing contact information for embassies and consulates worldwide
- Arrangements for an initial legal consultation if the covered person experiences a civil or criminal problem in a foreign country
- Emergency telephone translation services or referrals to interpreter services
- Help making travel arrangements for the family member chosen to join the covered person in hospital
- Travel arrangements for dependent children who are left on their own to return home
- Help replacing tickets, identification papers or other official documents that are lost or stolen, or if you need to return home early
- Pre-trip information such as information on passports, visas, required vaccinations and any restrictions that apply to each country the covered person is visiting, and
- Help finding lost or stolen luggage.

Travelling on Business?

The Bank has Emergency Out-of-Province/Country Health insurance coverage for Scotiabankers who travel on behalf of the Bank for business. If you are travelling on Bank business you are automatically covered under the Bank's plan for up to 60 days of travel.

For more information, and to print the wallet card visit the Business Travel Centre page on Scotiabank Live.

Critical Illness Insurance

What you should know

- Optional Critical Illness insurance pays a tax-free lump sum if you or your spouse is diagnosed with one of the 24 covered illnesses and survive at least 30 days following the diagnosis. Child Critical Illness insurance has a different list of 15 covered illnesses.
- You can buy up to $250,000 for yourself and your spouse and up to $25,000 for your children. You may not select an amount of coverage for your spouse and/or children that is higher than the amount you select for yourself.
- Critical Illness insurance will pay a benefit even if you are able to continue working or make a full recovery after diagnosis.
- Read the information about when benefits will and will not be paid carefully (see page 44-50), as not all illnesses are covered.
- Evidence of Insurability is required for any increase in coverage.
- On your first enrolment into the Canadian Benefits Plan, you can buy up to $100,000 of coverage for yourself and up to $50,000 for your spouse without providing Evidence of Insurability.
- A 12-month pre-existing condition exclusion will apply to any coverage obtained without Evidence of Insurability **on or after April 1, 2017** on all 24 illnesses. See page 50 for the definition of a pre-existing condition.
- You do not need Evidence of Insurability for Optional Child Critical Illness coverage.
- Critical Illness insurance is provided by SSQ Life Insurance Company Inc.

Coverage options

Insurance	Insured Person(s)	Coverage Summary
Optional Employee Critical Illness Insurance	You only	Units of $5,000 up to $250,000
Optional Spousal Critical Illness Insurance	Your spouse	Units of $5,000 up to $250,000
Optional Child Critical Illness Insurance *	Your child(ren)	Units of $5,000 up to $25,000

* The option you select will cover all your eligible dependent children, no matter how many children you have.

Eligibility

In addition to the Plan's eligibility rules (see page 7), you or your spouse must be under age 70 to be eligible for Optional Critical Illness insurance.

Evidence of Insurability

You must show Evidence of Insurability (see page 7) to buy coverage of more than:

- $100,000 for yourself
- $50,000 for your spouse

Evidence of Insurability is required for any new or increase in coverage

When coverage ends

In addition to when the Plan's coverage ends (see page 4), the following conditions apply for Optional Critical Illness coverage:

- Coverage ends for you and your covered dependents when you turn age 70.
- Your spouse's coverage ends on the day they turn age 70 even if your coverage is still in effect.
- Your child's coverage ends when they no longer meet the definition of an eligible dependent (see page 7).

When benefits will be paid

Covered critical illnesses differ depending on whether the coverage is for an adult or a child. If you or your spouse are diagnosed with a critical illness, the benefit is paid to the person with the illness. If your child is diagnosed with a critical illness, the benefit is paid to you.

Payment is subject to the limitations of the Survival Period and to the exclusions listed under "Exclusions".

You and your spouse

Critical Illness insurance pays a benefit if you or your spouse is diagnosed with one of the following critical illnesses and survives at least 30 days following the diagnosis:

- Alzheimer's Disease
  A diagnosis of a progressive degenerative disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The diagnosis of Alzheimer's Disease must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.
- Aortic Surgery
  The undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The Surgery must be determined to be medically necessary by a Specialist.

When benefits will be paid continued

- Benign Brain Tumour
  A diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The diagnosis of Benign Brain tumour must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

  Moratorium Period Exclusion: No benefit will be payable under this condition if within the first 90 days following the later of:

  – the effective date of the Insured Person's insurance; or

  – the effective date of last reinstatement of the Insured Person's insurance, such person has any of the following:

  - signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made; or

  - a diagnosis of benign brain tumour.

  This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for benign brain tumour or, any Critical Illness caused by any benign brain tumour or its treatment.

- Blindness
  A diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

  – the corrected visual acuity being 20/200 or less in both eyes; or

  – the field of vision being less than 20 degrees in both eyes.

  The diagnosis of Blindness must be made by a Specialist.

- Cancer (life-threatening)
  A diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of Cancer must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

  – carcinoma in situ; or

  – Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or

  – any non-melanoma skin cancer that has not metastasized; or

  – Stage A (T1a or T1b) prostate cancer.

  Moratorium Period Exclusion: No benefit will be payable under this condition if within the first 90 days following the later of:

  – the effective date of the Insured Person's insurance; or

  – the effective date of last reinstatement of the Insured Person's insurance, such person has any of the following:

  - signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the Policy), regardless of when the diagnosis is made; or

  - a diagnosis of cancer (covered or excluded under the Policy).

  This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

- Coma
  A diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less. The diagnosis of Coma must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for:

  – a medically induced coma; or

  – a coma which results directly from alcohol or drug use; or

  – a diagnosis of brain death.

- Coronary Artery Bypass Surgery
  The undergoing of heart Surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The Surgery must be determined to be medically necessary by a Specialist.

- Deafness
  A definite diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

When benefits will be paid continued

- Dilated Cardiomyopathy
  A condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac impairment. The diagnosis of Dilated Cardiomyopathy must be made by a Specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least three months.

  NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

  Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and nonprescription drug use) of dilated cardiomyopathy.

- Fulminant Viral Hepatitis
  A diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

  – a rapidly decreasing liver size as confirmed by abdominal ultrasound;

  – necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;

  – rapidly deteriorating liver function tests;

  – deepening jaundice.

  The diagnosis of Fulminant Viral Hepatitis must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for:

  – chronic hepatitis; or

  – Liver failure caused by alcohol toxins and/or drugs.

- Heart Attack
  A diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

  – Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

    - heart attack symptoms;

    - new electrocardiogram (ECG) changes consistent with a heart attack;

    or

    - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

  The diagnosis of Heart Attack must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for:

  – elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or

  – ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

- Kidney Failure
  A diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.

- Loss of Speech
  A definite diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

  Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

- Major Organ Failure on Waiting List
  A definite diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of diagnosis is the date of the insured person's enrollment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

- Major Organ Transplant
  A diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

- Motor Neuron Disease
  A diagnosis of one of the following:

  – Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);

  – Primary lateral sclerosis;

  – Progressive spinal muscular atrophy;

  – Progressive bulbar palsy; or

  – Pseudo bulbar palsy,

  The diagnosis of Motor Neuron Disease must be made by a Specialist.

When benefits will be paid continued

- Multiple Sclerosis
  A diagnosis of at least one of the following:
  - two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
  - well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
  - a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination, which have developed at intervals at least one month apart.

  The diagnosis of Multiple Sclerosis must be made by a Specialist.

- Muscular Dystrophy
  A diagnosis of all of the following:
  - clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
  - characteristic electromyography changes;
  - muscle biopsy confirming diagnosis of muscular dystrophy.

  The diagnosis of Muscular Dystrophy must be made by a Specialist.

- Occupational HIV
  A definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must occur while this coverage is in force.

  Payment under this condition also requires satisfaction of all of the following:

  (a) The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;

  (b) A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;

  (c) A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;

  (d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;

  (e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

  Exclusion: No benefit will be payable under this condition if:
  - the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or
  - a licensed cure for HIV infection has become available prior to the accidental injury; or
  - HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

- Paralysis
  A diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

- Parkinson's Disease
  A definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations:
  - muscle rigidity;
  - tremor; or
  - bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

  The diagnosis of Parkinson's disease must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for all other types of Parkinsonism.

- Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)

  A diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment. The diagnosis of Primary Pulmonary Hypertension must be made by a Specialist.

  The NYHA Classification of Cardiac Impairment (source: Current Medical diagnosis and Treatment-39th Edition) states the following about Class IV: "Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

  Exclusion: No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.

When benefits will be paid continued

- Severe Burns
  A diagnosis of 3rd degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

- Stroke (cerebrovascular accident)
  A diagnosis of an acute cerebrovascular event caused by intracranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:
  - acute onset of new neurological symptoms; and
  - new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

  These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of Stroke must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for:
  - transient ischaemic attacks; or
  - intracerebral vascular events due to trauma; or
  - lacunar infarcts which do not meet the definition of Stroke as described above.

If you or your spouse is receiving a benefit for being diagnosed with a covered critical illness, and is then diagnosed with another covered critical illness at least 90 days after your payment, you'll receive another critical illness benefit (subject to certain re-entry exclusions). This is known as multiple event coverage.

Re-entry exclusions

Certain critical illnesses are not covered if you or your spouse have been previously diagnosed with the same illness or an illness that may have contributed to the second illness. These illnesses are defined in the re-entry exclusions.

Your children

Critical Illness insurance pays a benefit if your child is diagnosed with one of the following critical illnesses:

- Blindness
  A diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:
  - the corrected visual acuity being 20/200 or less in both eyes; or
  - the field of vision being less than 20 degrees in both eyes.

- Cancer (life-threatening)
  A diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of Cancer must be made by a Specialist.
  Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:
  - carcinoma in situ; or
  - Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
  - any non-melanoma skin cancer that has not metastasized; or
  - Stage A (T1a or T1b) prostate cancer.

  Moratorium Period Exclusion: No benefit will be payable under this condition if within the first 90 days following the later of:
  - the effective date of the Insured Person's insurance; or
  - the effective date of last reinstatement of the Insured Person's insurance, such person has any of the following:
    - signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the Policy), regardless of when the diagnosis is made; or
    - a diagnosis of cancer (covered or excluded under the Policy).

  This medical information as described above must be reported to the insurer within six months of the date of the diagnosis. If this information is not provided, the insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

- Coma
  A diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less. The diagnosis of Coma must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for:
  - a medically induced coma; or
  - a coma which results directly from alcohol or drug use; or
  - a diagnosis of brain death.

When benefits will be paid continued

- Major Organ Transplant
  A diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

- Muscular Dystrophy
  A diagnosis of all of the following:
  - clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
  - characteristic electromyography changes;
  - muscle biopsy confirming diagnosis of muscular dystrophy.

  The diagnosis of Muscular Dystrophy must be made by a Specialist.

- Paralysis
  A diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

- Severe Burns
  A diagnosis of 3rd degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

- Cerebral Palsy
  The diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems. The diagnosis of Cerebral Palsy must be made by a Specialist.

- Congenital Heart Disease requiring Surgery
  The diagnosis of any serious cardiac malformation present at birth, for which corrective Surgery has been performed. The diagnosis of congenital heart disease must be made by a Specialist.

- Cystic fibrosis
  The diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems. The diagnosis of Cystic Fibrosis must be made by a Specialist.

- Deafness
  A diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of Deafness must be made by a Specialist.

- Down's Syndrome
  A congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present. The diagnosis of Down's Syndrome must be made by a Specialist.

- Loss of Speech
  A diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

- Mental Deficiency
  The diagnosis of an intellectual deficiency as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70. The diagnosis of Mental Deficiency must be made by a Specialist.

- Spina Bifida Cystica
  Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:
  - hydrocephalus;
  - paralysis;
  - bowel problems; and
  - bladder problems.

  The diagnosis of Spina Bifida Cystica must be made by a Specialist.

  Exclusion: No benefit will be payable under this condition for Spina Bifida Occulta

Multiple event coverage does not apply to children.

When benefits will be paid continued

Re-Entry Exclusions

If a claim was made for a Critical Illness shown in the left column of the table below, no claim can be made for an illness listed in the right column.

Critical Illnesses claimed for	Re-entry exclusions (Illnesses for which the Insured Person cannot claim
Alzheimer's Disease	Alzheimer's Disease
Aortic Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Artery Bypass Surgery, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Benign Brain Tumour	Benign Brain Tumour, Blindness, Coma, Paralysis, Stroke
Blindness	Blindness
Cancer (life-threating)	Cancer (life-threating)
Coma	Blindness, Coma, Paralysis, Stroke
Coronary Artery Bywpass Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Artery Bypass Surgery, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Dilated Cardiomyopathy	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Artery Bypass Surgery, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke, Dilated Cardiomyopathy
Fulminant Viral Hepatitis	Cancer (life-threating), Fulminant Viral Hepatitis, Major Organ Failure on Waiting List, Major Organ Transplant
Heart Attack	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Artery Bypass Surgery, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Kidney Failure	Coma, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Major Organ Failure on Waiting List	Cancer (life-threating), Coma, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Major Organ Transplant	Cancer (life-threating), Coma, Heart Attack, Kidney Failure, Major Organ Failure on Waiting list, Major Organ Transplant, Stroke
Motor Neuron Disease	Blindness, Coma, Heart Attack, Motor Neuron Disease, Paralysis, Stroke
Multiple Sclerosis	Blindness, Coma, Kidney Failure, Multiple Sclerosis, Paralysis, Stoke
Muscular Dystrophy	Blindness, Coma, Dilated Cardiomyopathy, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke
Paralysis	Coma, Paralysis
Parkinson's Disease	Coma, Paralysis, Parkinson's Disease
Primary Pulmonary Hypertension	Aortic Surgery, Coma, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, Stroke
Severe Burns	Paralysis, Severe Burns
Stroke (Cerebrovascular Accident)	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Artery Bypass Surgery, Heart Attack, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

When benefits will not be paid

Benefits are not paid for critical illnesses resulting from any of the following causes or situations:

- If, within 90 days after coverage begins, a covered person is diagnosed with, or has any signs/symptoms that eventually result in a diagnosis of cancer or a benign brain tumour.
- A cancer diagnosed before your coverage begins recurs or metastasizes after your coverage begins.
- A covered person does not live for 30 days after a covered critical illness is diagnosed.
- An injury or sickness is intentionally self-inflicted.
- Illicit drugs are used other than prescribed by a medical practitioner, or
- A newly diagnosed critical illness conflicts with the re-entry exclusions.

A 'pre-existing condition' means:

- the existence of symptom(s) within a twelve (12) month period preceding the covered person's effective date of individual coverage which would cause a reasonably prudent person to see diagnosis, care or treatment; or
- an illness or condition for which the covered person, during twelve (12) months prior to the effective date of individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a physician.

Critical Illness Conversion Privilege

In the event your coverage is terminated as a result of any of the following reasons, you may obtain an individual Critical Illness policy by providing a written application to the Insurer within 45 days of:

- termination of your employment; or
- your ceasing to be eligible for this benefit; or
- the period where you are totally disabled comes to an end but you did not return to work for Scotiabank.

The Insured Person who has not yet reached the age of 70 may make a written application to the Insurer within 45 days of said termination to obtain an individual Critical Illness policy. On reception of such application, the Insurer will, without evidence of insurability, issue on the life of such Insured Person an individual Critical Illness policy to the applicant that will consist of four illnesses [Cancer (life-threatening), Coronary artery bypass surgery, Heart Attack and Stroke].

However, conversion will not be possible if the Policy is terminated at the time of the application. An Insured Person may only convert if they have never received a Critical Illness coverage payment and has never received a payment under the "Complementary Benefit in Case of Certain Illnesses" section in the past.

The amount of insurance that may be converted will not exceed the lesser of:

- the amount of insurance then in effect on the date of termination; or
- a total aggregate amount of $250,000 for all such conversions by any Insured Person.

Premiums for such an individual Critical Illness policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates then in force for the attained age of such Insured Person at the date of conversion. Premiums will be payable annually in advance and the Critical Illness policy will be issued on an annually renewable basis.

Health Care Spending Account

What you should know

- You can transfer unused credits into a tax-free (except in Quebec) Health Care Spending Account to pay for Health and Dental costs not covered by the Plan, a spousal plan or a provincial or territorial plan.
- You must use the full balance of your Health Care Spending Account each Plan year. You can't carry credit balances forward from one year to the next.
- Your Health Care Spending Account credit allocation can only be changed during the annual re-enrolment period and cannot be changed during a Work/Life Event.
- You can use the funds in your Health Care Spending Account to cover eligible expenses for dependents not covered by the Canadian Benefits Plan.
- The Plan year for Health Care Spending Account participation is April 1 to March 31.
- The Health Care Spending Account is administered by The Manufacturers Life Insurance Company (Manulife).

Eligibility

The definition of eligible dependents is broader for your Health Care Spending Account, than for the Plan (see page 7). You can use your Health Care Spending Account to claim for expenses incurred by other relatives who are financially dependent on you if they're also eligible to be claimed as an income tax exemption. These can include your parents, grandparents, brothers, sisters, nieces, nephews, grandchildren and children, or those of your spouse. When you submit your Health Care Spending Account claim, you must indicate their relationship to you on the claim form.

What is covered

You can use your Health Care Spending Account to pay for any expenses that qualify as a "medical expense" under the Income Tax Act (Canada) including:

- Fees charged by Health and Dental practitioners
- Health and dental expenses, and
- Medical devices and supplies

To find out if an expense is eligible, call Manulife directly at 1-800-268-6195.

Carrying expenses forward

You can't carry forward Health Care Spending Account credit balances from one year to the next. They expire at the end of the Plan year. However, you can carry forward any of this year's eligible expenses for payment from the next year's Health Care Spending Account allocation. If you did not have an Health Care Spending Account the year the expense was incurred, you will not be able to carry forward the expense.

Wellbeing Account

What you should know

- The Wellbeing Account allows you to use unused credits to improve your physical, financial, mental and social wellbeing.
- Any expenses reimbursed from the Wellbeing Account are considered taxable income and reported as income to you.
- You must use the full balance of your Wellbeing account each Plan year. You can't carry credit balances forward from one year to the next.
- Your Wellbeing Account credit allocation can only be changed during the annual re-enrolment period and cannot be changed during a Work/Life Event.
- The Plan year for the Wellbeing Account participation is April 1 to March 31.
- The Wellbeing Account is administered by The Manufacturers Life Insurance Company (Manulife).

Eligibility

The definition of eligible dependents is broader for your Wellbeing Account, than for the Plan (see page 7). You can use your Wellbeing Account to claim for expenses incurred by other relatives who are financially dependent on you if they're also eligible to be claimed as an income tax exemption. These can include your parents, grandparents, brothers, sisters, nieces, nephews, grandchildren and children, or those of your spouse. When you submit a Wellbeing Account claim, you must indicate their relationship to you on the claim form.

Carrying expenses forward

You can't carry forward Wellbeing Account credit balances from one year to the next. They expire at the end of the Plan year. However, you can carry forward any of this year's eligible expenses for payment from the next year's Wellbeing Account allocation. If you did not have a Wellbeing Account the year the expense was incurred, you will not be able to carry forward the expense.

What is covered

Expense category	Eligible products & Services
Memberships and classes	• Health club membership, gym membership (e.g. Good Life, YMCA, etc.) • Fitness programs, fitness classes • Self defence classes (e.g. Yoga, Pilates, Spinning, Running Room, skating, dance lessons, etc.) • Sport registration fees, team fees • Personal trainer
Fitness and sports equipment	• Home fitness equipment (e.g. treadmills, elliptical machines, rowing machines, etc.) • Electronic fitness tracking devices (e.g. FitBit, Apple Watch, etc.) • Bicycles, tennis racquets, golf clubs • Speciality equipment (hockey equipment, baseball equipment, safety helmets, etc.) • Athletic apparel (yoga pants, ski jackets, etc.) • Footwear (including running shoes, skates, dance shoes, golf shoes, baseball shoes, etc.)
Health care support products and services	• Nutritional services • Wellness apps • Medic Alert bracelet/neck chain • Smoking cessation programs • Maternity services (prenatal classes, mid-wife, doula services) • First aid and CPR training • Instructional videos, DVDs or literature
Extended Family Care Support	• Child day care centre • Child care expenses (i.e. diaper service and diapers, car seats/booster seats and baby monitors) • Emergency child care expenses (i.e. Kids & Company back-up child care passes) • Mental health services for extended family members (e.g. parent/adult child) • Children's camps (i.e. day camps or overnight camps) • Adult/elder care expenses (i.e. retirement homes, Meals on Wheels, nursing home expenses, etc.) • Day Away programs • Expenses related to tutoring services (i.e. discounted tutoring services from TutorBright)
Insurance Expenses	• Premiums (i.e. Long-term disability, Life insurance, Critical Illness and Accidental Death and Dismemberment) • Broker fees • Home and content insurance • Car insurance and other vehicle insurance (i.e. boat, skidoo, etc.) • CAA membership • Pet insurance
Home Office Equipment	• Printers, monitors, headset, mouse, printer ink, printer paper, office chair, office desk, internet costs, etc.
Grocery and Food Delivery Services	• Meal delivery (e.g. UberEats, Doordash, Foodora), restaurant delivery/takeout, groceries and related delivery fees, meal prep services, etc.

To find out if an expense is eligible, contact Manulife directly at 1-800-268-6195.

What is not covered

- Services provided by family members
- Fees related to the delivery, service, or maintenance of equipment (e.g., repair to an exercise bicycle)

Group RRSPs

What you should know

- You may register and contribute to one of either Scotia McLeod RRSP or Scotia iTrade RRSP, but not to both. This applies to contributions made through both payroll deductions and unused credits. However, you may still register and contribute to both a Manulife RRSP and one of a Scotia McLeod RRSP or a Scotia iTrade RRSP.
- A Scotia McLeod RRSP or Scotia iTrade RRSP account must be opened within 60 days. If an account is not opened, any unused credits that you've allocated to either RRSP will default to your Health Care Spending Account.
- The Scotia McLeod RRSP and Scotia iTrade RRSP have a minimum recommended plan value of $100,000 and $25,000, respectively.
- Both the Scotia McLeod RRSP and Scotia iTrade RRSP plans require a $25 minimum monthly payroll contribution.
- Please refer to the Group RRSP policy on Ask HR for more information on how to open an account.

Eligibility

You are eligible to participate in a Group RRSP if you are:

- A regular status employee; or
- A contract employee who is also eligible for the Canadian Benefits Plan.

If you are a contract employee and not eligible for the Canadian Benefits Plan, you are only eligible to contribute to a Scotia McLeod RRSP or a Scotia iTrade RRSP. You are not eligible to contribute to the Manulife Group RRSP.

Wellbeing Programs and Services

What you should know

- In addition to Health and Dental coverage as well as other insurance, the Bank also provides access to health and wellbeing support services. These include Teladoc Medical Experts, Employee and Family Assistance Program, Carepath, Kids & Company, Manulife Vitality, WorkPerks, TutorBright and LifeSpeak.
- These Bank-paid programs cover such services as support for serious medical conditions, counseling, work-life solutions and illness prevention.

Teladoc Medical Experts

Teladoc Medical Experts provides access to medical experts to help you find the right information about your diagnosis and treatment plan. Teladoc Medical Experts is available to your parents and spouse's parents living in Canada.

Covered Services:

- Expert Medical Opinion

  Provides a review of your condition to confirm if you have the right diagnosis and/or the right treatment plan.

  Teladoc Medical Experts will provide an in-depth study of your case, collect your medical records, pathology (when applicable) and provide a report with their recommendation(s), containing an expert review that brings greater certainty to your diagnosis and treatment plan.

- Mental Health Navigator

  This confidential virtual service is available if you would like more information about mental health services near you, feel like your treatment isn't working, or your condition isn't improving. Mental health clinicians are available to point you in the right direction when it feels like you've lost your way.

- Personal Health Navigator

  This service offers resources and information on a wide variety of health-related topics.

- Find a Doctor

  Teladoc Medical Experts will conduct a customized search guided by your criteria and geographic preference, and will recommend specialists that are accepting new patients.

* Access to a Canadian specialist requires a referral from a treating physician. Expenses associated with medical treatment, travel and lodging relating to Find a Doctor are the responsibility of the employee. Medical treatment expenses may be eligible under the Plan.

- Care Finder

  If your medical condition requires treatment from a specialist outside of Canada,* a Teladoc Medical Experts Member Advocate will search their global database. They will provide you with up to three recommendations. Teladoc Medical Experts will also contact each doctor or treatment facility to ensure they're accepting new patients, and provide background information on each doctor.

* Expenses associated with medical treatment, travel and lodging relating to Care Finder are the responsibility of the employee.

- Ask The Expert℠

  If you are seeking a more detailed understanding of your medical condition or treatment options, The Ask the Expert™ service can help. A leading physician who specializes in your condition will provide written answers to your questions.

Contact Teladoc Medical Experts at 1-877-419-2378, or visit www.teladoc.ca/medical-experts. (Note: this is a general information website, not all services listed are available under Scotiabank's Teladoc Medical Experts service agreement.)

Employee and Family Assistance Program

Scotiabank offers a comprehensive Employee and Family Assistance Program to all employees and their eligible dependents through Dialogue.

Dialogue's Employee and Family Assistance Program gives you immediate virtual access to integrated mental health support, work and career counseling, support for families and relationships, and legal and financial advice.

The following types of concerns are examples of what can be addressed through the Employee and Family Assistance Program. Depending on the type of concerns, you and your dependents may have access to up to six sessions per issue at no cost to you. Expenses for additional sessions may be eligible for reimbursement under Mental Wellbeing Services.

Mental Health

- Mood disorder symptoms (depression, anxiety, etc.)
- Adjustment disorders
- Stress management
- Sleep issues & fatigue
- Anger & emotional regulation
- Grief & bereavement
- Problematic substance use
- Life stages
- Self-esteem
- Social isolation

Family & Relationship

- Caregiver related concerns
- Relationship breakdown & separation
- Improving communication
- Conflict resolution
- Family dynamics
- Communication
- Intimacy issues
- Blended family
- Adolescent & child behaviour
- Family planning
- Parenting
- Domestic violence
- Work & career
- Child care
- Elder care
- Legal counselling on questions relating to civil, family, criminal, property and will/estate law
- Financial support

Management Consultation to Managers/Supervisors:

The Program is available to help you manage through a situation that you may not know how quite to handle.

Your counsellor will work with you to identify strategic solutions and build action plans to help you resolve sensitive employee issues. Your counsellor will work with you as a manager/supervisor and discuss available resources and the best way to support either an individual employee or your team.

To access the Employee and Family Assistance Program, visit https://pages-support.dialogue.co/eap-scotiabank/. (Note: this is a general information website, not all services listed are available under Scotiabank's Employee and Family Assistance Program service agreement.)

Visit the App store or Google Play to download the Dialogue app.

Carepath – Cancer Assistance Program and Elder Care Program

Cancer Assistance Program

The Cancer Assistance Program is a comprehensive program that provides Scotiabankers and their eligible dependents recently diagnosed with cancer or a cancer reccurence with ongoing, one-on-one, telephonic counseling, guidance and support by a personal oncology nurse, backed by oncology physicians.

Your Carepath nurse will be there every step of the way, through treatment, recovery and into survivorship, addressing all questions and working with you, your family and doctors to ensure all of your emotional, medical and treatment needs are met and that everything possible is being done to help.

The program is based on the most up-to-date, reliable and evidence-based information available and is directed and delivered by world-renowned oncology physicians and highly trained and caring oncology nurses.

Get started by calling 1-866-883-5956 or emailing Carepath at info@carepath.ca

Elder Care Program

The Elder Care Program, the only service in Canada that connects you, your immediate family and parents to a Registered Nurse who will help you understand your senior care choices and ensure you get the right care every time.

The Elder Care Program delivers on the following three crucial aspects of home care – CONNECT, ACCESS and CARE.

- Connect you, your family and parents to publically funded senior care resources such as prescription drug financial support programs, home and community care services, assistive devices, and home renovation grants.
- Provide access to seniors care support services including access to the Senior Living Advisor personalized service to help you find the right senior living community.
- Care to ensure that services, such as nursing, personal care, companionship, home support, house cleaning, home retrofit, and meal deliveries are provided by organizations that you and your family can trust.

Call 1-866-883-5956 or visit www.carepath.ca

Kids & Company

Kids & Company is a national child care provider offering both day-care centre and back-up childcare for newborns to kids up to age 12. In addition, through a partnership with First Health Care, Scotiabankers also have access to 24-hour, private in-home Elder Care programs.

Scotiabank employees can gain access to five Bank-paid back-up visits per child per year, with 24 hours notice. Discounted childcare rates for full-time and part-time childcare are also available.

The membership to Kids & Company is paid for by the Bank; however, you are responsible for all costs related to the service(s) you select. All fees are paid directly to the vendor.

Back-up Childcare

Provides last-minute care for your child whenever you need it, such as: your child's regular caregiver is sick or school is canceled.

Guaranteed Spot at a Kids & Company Day Care Centre

With locations from coast-to-coast, Scotiabankers are guaranteed a spot in a Kids & Company affiliated day care with as little as six months' notice.

In-home Childcare

Kids & Company has partnered with several highly accomplished Nanny agencies who will work with you to find qualified, experienced and nurturing child care providers to fit your specific needs.

To access Kids & Company, call 1-866-MYKIDCO (695-4326) or visit www.kidsandcompany.com

Manulife Vitality

- Manulife Vitality provides personalized weekly goals so you can plan little steps towards a healthier you - and rewards you along the way.
- This program offers a variety of ways for you to learn about and improve your health, from choosing simple activities like eating well and exercising to completing health assessments.
- The more engaged you are and the healthier your choices, the more points you can earn towards rewards.

Here's how to get started

Step 1 - Sign up

Go to Manulife Plan Member Site through *Pay and Benefits* in me@scotiabank.

Click the button called 'Sign up for Manulife Vitality' on the first page.

Step 2 - Download the free app on your mobile device

You can get it in the App Store and Google Play. Look for Manulife Vitality Grp Benefits.

Step 3 - Sign in

After you download the app, open it.
Enter your employee number to sign in.

WorkPerks

WorkPerks is an employee discount program that offers you and your family with over 3,000 discounts and savings opportunities from leading brand name companies and trusted local businesses. Discounts typically range between 10% and 40%. The program is administered by a third party vendor, Venngo.

You can access WorkPerks through me@scotiabank > Pay and Benefits > My Benefits > WorkPerks.

Visit the App store or Google Play to download the Venngo app for WorkPerks. You will need your active WorkPerks account to sign in to the mobile app.

TutorBright

Employees have access to discounted fees for tutoring services through TutorBright, a virtual tutoring provider, on all subjects from Kindergarten to Grade 12 and in many cases helps children with specific learning needs.

Their video conferencing technology simulates in-person face-to-face tutoring. The tutor and student can interact in real time using audio, video, and a shared whiteboard where students and tutors can simultaneously work on homework, assignments, and more.

To access TutorBright, call 1-855-853-1200 or visit www.tutorbrightpartner.com

LifeSpeak

LifeSpeak is a health, wellness and professional development platform, which gives Scotiabankers and their family members instant access to expert advice on all kinds of topics such as mental health, heart disease, stress and more. You can watch videos, download action plans, and interact with world-class experts in real time.

To access LifeSpeak, visit https://scotiabank.lifespeak.com and use access ID **lifespeak**.

Visit the App store or Google Play to download the LifeSpeak app.

How to Submit Health and Dental Claims

You can find detailed information about submitting claims on Manulife's Plan Member Site, which you can access through me@scotiabank > *Pay and Benefits > My Benefits > Canadian Benefits Plan Member Site*.

Submission deadlines

To be reimbursed for eligible expenses under your Health and Dental coverage, Health Care Spending Account and Wellbeing Account, your claim must be received by Manulife within 90 days of the end of the Plan year, which is March 31. This means Manulife must receive your claim by June 30.

Pay direct claims (benefits card)

Under all coverage levels, Manulife gives you a benefits card that allows your pharmacist to submit your prescription drug claim electronically to Manulife at point of purchase. The online system calculates the amount covered by the Plan, and you pay the rest. Other service providers, such as your dentist, may also be able to submit your claims this way. Please check with them.

Online claims

You can submit online claims through Manulife's Plan Member Site and the Manulife Group Benefits Mobile App. You'll be reimbursed for approved claims through direct deposit to your account.

Keep your receipts

If you submit your claims online, you don't have to send in your receipts. You must keep proof of your claims, for at least one year.

Paper claims

Send paper claims to the address printed on the claim form accessible from the Manulife Plan Member Site in the Pay and Benefits tile in me@scotiabank. Be sure to include your plan member certificate number on all correspondence and claim forms. You'll be reimbursed for approved claims through direct deposit to your account.

Accident

A sudden and unexpected mishap or event in which an Insured Person is involved and which directly results in an Injury to the Insured Person.

Accommodation

Lodging at a hotel, motel, inn, bed and breakfast or other like establishment as well as food reasonably required during the lodging, provided however that no indemnity would be paid for lodging at a private residence or for food not consumed as meals by the person seeking reimbursement of expenses.

All-source Maximum

The Plan sets a limit on your combined income from all sources during your Long-term Disability leave. This maximum covers benefits from government plans (such as workers' compensation and Canada/Quebec Pension Plan [CPP/QPP] employee disability benefits), employer plans, other employment income and third-party payments. The all-source maximum is 85% of your net monthly Benefits Salary. That is, your Benefits Salary less deductions for federal and provincial income taxes, CPP / QPP contributions and federal Employment Insurance premiums. If your combined income during your Long-term Disability leave exceeds this maximum, Canada Life can recover the excess.

Premiums paid in respect of coverage in excess of the all-source maximum will not be refunded.

Alternate Benefit Clause

If more than one dental treatment option is available, you'll be reimbursed for the least expensive treatment that provides the same professionally adequate result.

Benefits Salary

If you are a regular full-time employee, your Benefits Salary is your annual base salary. It may include shift allowance, but excludes overtime and Annual Incentive Payments. For other employees, the Benefits Salary is calculated every year as follows (up to $250,000 for Long-term Disability and Core Employee Life insurance);

Commission-based (variable-pay employees): Base salary, plus the average of the previous three years' commissions and various payments, if they apply.

Part-time employees: Annualized rate of pay based on your regularly scheduled hours (i.e. hours agreed to in, or subsequent modification to, your employment contract, and not actual hours worked in any given period), but excluding overtime and Annual Incentive Payments.

Burn

A condition, which a Physician has determined to be a third degree burn.

Commencement of Total Disability

The date of commencement of the Insured Person's Total Disability, as determined by a Physician, which date must be subject to the satisfaction of the Insurer that, on that date, the Insured Person has met all criteria for Total Disability.

Common Accident

A single Accident or multiple Accidents occurring within the same 24-hour period.

Daily Indemnity

One-thirtieth of one percent (1/30 of 1%) of the Insured Person's Principal Sum, subject to a maximum monthly indemnity of $2,500.

Day-Care Centre

A facility which is run according to the law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. A Day-Care Centre will not include a hospital, the child's home or school if the only care at such school is provided during normal school hours while the Dependent Child is attending school from grades one through 12.

Day of Hospitalization

The necessary Period of Hospitalization in a Hospital as an inpatient for which a full day's room and board is charged.

Diagnosis or Diagnosed

The time when a Specialist establishes, using tests or other diagnostic methods, that the Insured Person has a specific Critical Illness. The diagnoses of any covered Critical Illness must be made by a licensed Specialist practicing in Canada. Furthermore, his practice must be limited to the branch of medicine directly linked to the Critical Illness for which benefit is being claimed.

Employee Only Plan

A plan, which provides insurance to the Employee only.

Employee plus one Dependent Plan

A plan, which provides insurance to the Employee and one Dependent.

Fare

The regular fare charged for the following:

1. an economy class seat on a regular flight by a domestic or international scheduled air carrier;
2. a coach seat on a passenger train;
3. a regular seat on a passenger bus;
4. an economy class accommodation on a boat.

Each of those carriers must hold a current and valid certificate issued by Transport Canada or, if subject to regulation in another country by a similar governmental authority having jurisdiction in that country.

Functional Disability

An irreversible and serious limitation of a person's physical or mental capacity or of their skills that prevents the person from living independently.

Hospital

An institution licensed as a hospital within the jurisdiction in which it operates. To qualify under this definition, a hospital must be an active treatment hospital open at all times for the care and treatment of sick and injured persons, have a staff of one or more Physicians available at all times, provide 24-hour nursing service by graduate registered nurses and have organized facilities for diagnostics and surgery. A facility, which is primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment, is not a Hospital. For the purposes of this definition, a Hospital will include a facility or part of a facility used for rehabilitative care. Physicians and Nurses will not exclude an Immediate Family Member.

Immediate Family Member

A person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, uncle, aunt, nephew, niece, grandson, granddaughter, grandfather, grandmother (all of the above include natural, adopted or step relationships) or the spouse of an Insured Person.

Injury

Bodily injury caused by an Accident occurring while the Policy is in force as to the Insured Person whose loss is the basis of claim and resulting directly and independently of all other causes in loss covered under the Policy, 24 hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

Institution for Higher Learning

Universities, Colleges, CEGEPs and professional or vocational schools

Insured Person

You or your insured Spouse or your insured Dependent Child or Dependent Children, while meeting the Spouse and Dependent Child definition criteria presented in this section, and before the date of individual coverage termination.

Intoxicated/Under the Influence of Drugs

When a driver has a blood alcohol content and/or is impaired due to the use of alcohol, narcotics or other drugs such that he could be subject to proceedings under provincial, state or federal law, even if he has not been subject to such proceedings.

Irreversible

The condition cannot be improved by medical or surgical treatment at the time of diagnosis. The medical or surgical treatment need not to be undertaken if it would involve an undue risk to the Insured Person's health.

Life Event

Any one of the following events:

- Marriage, civil union or 12-month anniversary of a common-law relationship
- Divorce, separation or end of common-law relationship
- Add a dependent child (birth, adoption, legal guardianship or gain a stepchild)
- Death of a spouse or child
- Loss of a child's status as a dependent (marriage, birthday or leaves school).
- Child regains status as a dependent (returns to school)
- An Insured Employee's spouse loses benefits coverage due to loss of employment

Life Support

The Insured Person is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation all functions of the brain has occurred.

Motorized Vehicle

A passenger car, van, jeep-type automobile, sports utility vehicle (SUV), any truck-type automobile, truck, ambulance, or any type of motorized vehicle used by municipal, provincial or federal police forces.

Non-Smoker

- You and/or your spouse must not have used any tobacco products for at least 12 consecutive months prior to enrolling.
- If you declare yourself or your spouse to be a smoker, you will notice higher costs for optional health care coverage. Cost for core Health coverage will remain unchanged.

If you or your spouse begin or resume smoking, it is your responsibility to call Manulife directly at 1-800-268-6195 to update your status. Your premium rates will be adjusted accordingly.

Normal Place of Residence

The place where the insured persons reside (meaning sleep, eat, pays their taxes, their home, their house, the place they go back to every day after work).

Nurse

A graduate registered nurse (R.N.) or nurse who is licensed to practice nursing service by a governmental agency having jurisdiction over such licensing. Nurse is neither the Insured Person himself nor an Immediate Family Member.

Period of Hospitalization

A single uninterrupted confinement in a Hospital or several successive confinements in a Hospital because of the same Accident provided each such confinement is separated by a period of less than 90 consecutive days and all such confinements occur within 730 days of the date of the Accident.

Physician

An individual who is legally licensed to practice medicine and provide treatment within the scope of his license by:

(a) a recognized medical licensing organization in the jurisdiction where the treatment is rendered provided he is a member in good standing of such licensing body, or

(b) a governmental agency having jurisdiction over such licensing where the treatment was rendered. The Physician must not ordinarily reside in the Insured Person's residence.

The Physician must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

An individual who is legally licensed to practice medicine in Canada and provide treatment within the scope of his license. The Physician must not be the Insured Person, a relative of or business associate of the Insured Person.

Plan Year

Coverage under the Canadian Benefits Plan is limited to a 12-month period each plan year April 1 to March 31.

Policyholder

Scotiabank (The Bank of Nova Scotia).

Principal Sum

The amount applicable to the Insured Person, as listed under the Schedule of Benefits.

Professional Counselor

A therapist or counselor who is licensed or registered within the jurisdiction in which he practices to provide psychological treatment or counseling. The Professional Counselor must not ordinarily reside in the Insured Person's residence. The Professional Counselor must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

Reasonable, Usual and Customary Charges

Reasonable, usual and customary charges are the lowest of the following:

- the usual charge for the same or comparable service or supply in the area in which the charge in incurred, as decided by the administrator
- the amount shown in the applicable professional association fee guide, and
- the maximum price established by law

Regular Care and Attendance

Observation and treatment to the extent necessary under existing standards of medical practice for the condition requiring such treatment or causing Hospital confinement.

Residence

The primary dwelling of which the Insured Person is an occupant and the premises on which it is situated.

Seat Belt

A belt that forms a restraint system in a Motorized Vehicle.

For the purposes of this definition, a Seat Belt includes infant and child restraint systems used in Motorized Vehicles and the restraining belts, which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

Sickness or Disease

The alteration of a person's state of health resulting from internal or external cause(s, creating objectively verifiable symptoms and/or signs, and revealing itself by the impairment of physiological or mental functions.

Smoker

If you indicate that you and/or your spouse are non-smokers and at the time that you die it is determined that you and/or your spouse have smoked since making the declaration, the insurance plan may not pay the benefit to you or your beneficiaries. If you and/or your spouse begin or resume smoking, it is your responsibility to call the Global HR Services to update your status. Your premiums rates will be adjusted accordingly.

Specialist

A licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be Diagnosed by a qualified Physician practicing in Canada. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative of or business associate of the Insured Person.

Specific Loss

Loss of Life, Loss, Loss of Use, Quadriplegia, Paraplegia or Hemiplegia, all as previously defined.

Surgery

That the Insured Person undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada.

Survival Period

30 days following the date of diagnosis or 30 days following the date of Surgery, if applicable, except where otherwise specified under the Policy. The Survival Period does not include the number of days of Life Support as defined in this policy. The Insured Person must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain. For those conditions which have a qualifying period, for example 90 days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Total Disability

Directly refers to a continuous state of incapacity preventing the Insured Person from performing all of the usual and customary duties of his occupation.

An Insured Person will be deemed Totally Disabled only if he does not receive any income from any occupation after the Commencement of Total Disability, directly or indirectly, except in the context of a rehabilitation program approved by the Insurer.

For a Total Disability to be recognized, the state of the Insured Person must require Regular Care and Attendance by a Physician or an appropriate specialist. Proof of Regular Care and Attendance must be satisfactory to the Insurer.

Transportation

Conveyance from one place to another by private or public Motorized Vehicle, bus, train, boat, ferry, airplane or helicopter.

Travelling Companion

A person who is sharing the same booked accommodation with the Insured Person.

Travelling on Company Business

Any travel undertaken as part of the normal duties of the Insured Person's occupation with the Policyholder, but excluding commuting to or from the Insured Person's workplace.

Trip

Travel, undertaken by the Insured Person, which commences on the date of departure from the Insured Person's province of Residence and continues until the return date to his province of Residence, subject to a maximum duration of 45 consecutive days.

Work Event

Any one of the following events:

- Change from full-time to part-time (or vice versa)
- Change from Contract to Regular (or vice versa)
- Going on and returning from leaves of absence (including maternity and parental leave) and disability (excluding Short-term Disability)