enVia

HEALTH SPENDING ACCOUNT

eHSA Health Spending Account

A revolutionary individual benefits program that's best for:

Incorporated Business Owners • Employer Groups • Seniors • Families with a "special needs" child • Contractors

With an enVia Health Spending Account, you'll enjoy a much broader range of claimable health & dental expenses - and freedom from the annual cost increases typical of traditional benefit plans - with no wasted premiums, deductibles or co-payments.

Key Features:

- Much wider range of claimable expenses with no wasted premiums - unused funds carry forward 1 year.
- Not a traditional insurance plan, rather a tax-deductible "private health services plan" allowing employers to write off employees' health & dental expenses.
- Esorse Hybrid Pay-Direct Visa® Health Benefits Card included for immediate claims payment.
- Automatically includes "Excess Medical Insurance" to cover any sudden, unanticipated expensive claims for prescription drugs, ambulance, assistive medical devices, durable medical equipment, hospital or home nursing (To qualify, employee must work at least 20 hours per week).
- Includes Special Risk AD&D Insurance, Travel Attaché Services & Employee Assistance Program.

Includes Hybrid Visa® Pay-Direct Health Benefits Card

How does it work?

It's like a Health & Dental bank account - tax-deductible monthly/annual deposits are made and these funds are used for healthcare expenses.

What expenses does an HSA cover?

The HSA opens up a whole new world of claimable expenses not covered under traditional plans, all with 100% reimbursement and no deductibles or co-pays!

Here are some sample expenses you can claim with an HSA:

Acupuncture*	Contact Lenses**	Hydrotherapy**	Oxygen & Equipment	Therapy Equipment
Artificial Limbs	Contraceptive Devices**	Insulin & Diabetic Supplies	Physiotherapist	Vein Removal
Athletic Therapy*	Crowns & Bridgework	Laser Eye Surgery	Podiatrist	Viagra, Cialis, Levitra
Attendant Care	Dental Implants & Veneers	Naturopathic Products**	Prescription Drugs	Vitamins**
Birth Control Pills**	Dental Treatment	Occupational Therapist	Psychologist	Wheelchairs
Breast Reduction Surgery	Dentures	Optician	Psychotherapy*	X-rays
Chinese Medicine*	Dermatologist Fees***	Optometrist	Psychiatrist	& more****
Chiropractor	Fertility Treatments	Orthodontics / Dental Braces	Registered Masseur	
Chiropodist	Gastric Bypass / Stapling	Orthopedic Shoes	Non-Cosmetic Skin Care***	

* Must be performed by a licensed medical practitioner;
** Must be prescribed by a licensed medical practitioner and dispensed by a licensed pharmacist / medical practitioner as part of their medical services;
*** Must be medically necessary;
**** As per Section 118.2 (2) of the Federal Income Tax Act and Interpretation Bulletin IT-519R2.

Please visit **www.enVia.ca**
or call toll-free: **1-877-755-9670**

Scotiabank® is a Registered trademark of The Bank of Nova Scotia.
* Visa Int./Lic. user The Bank of Nova Scotia.
Excess Medical Insurance is underwritten by the Western Life Assurance Company.

enVia
HEALTH SPENDING ACCOUNT

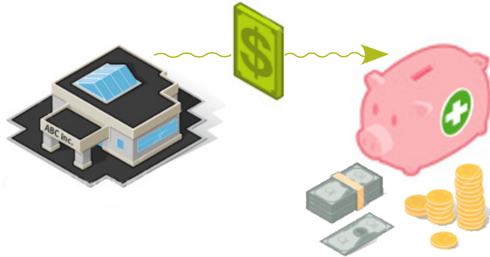
Key Concepts Explained

For most people, the **enVia Health Spending Account** represents a new way of covering your Health & Dental Expenses. Please review the following key points to learn how this program is different from a traditional group insurance plan. We're happy to answer any questions you may have - please contact us as indicated below if you need more information!

A How the enVia Health Spending Account (eHSA) works:

1. First, the Employer determines an annual contribution amount (ranging from $1,000 to $50,000 or more) for employees working at least 20 hours per week.

2. Next, monthly contributions are deposited to individual accounts.



Date	Transaction Description	Amount		eHSA Balance
		Debit	Credit	
Jan 1	Initial Employer Contribution		$125.00	$125.00
Jan 6	Prescription Drug Claim	$75.00		$50.00
Feb 1	Monthly Employer Contribution		$125.00	$175.00
Feb 15	Massage Therapy Claim	$60.00		$115.00
Mar 1	Monthly Employer Contribution		$125.00	$240.00
Mar 12	Eyeglasses Claim	$300.00		-$60.00
Apr 1	Monthly Employer Contribution		$125.00	$65.00

3. Individual uses funds in eHSA to pay for health & dental expenses. Current balance can be checked online 24/7.

4. Pay-direct Visa® Card used to pay for expenses. Online claims submission by all Professionals & Service Providers.

5. Reimbursement is 100% with no deductible or co-pay. If current balance is less than submitted claim, reimbursement will be made once monthly contributions allow.

B What is Excess Medical Insurance & how does it work?

Your HSA automatically includes $1 million lifetime of Excess Medical Insurance, underwritten by the Western Life Assurance Company, to provide an additional "umbrella of protection" in the event of a sudden serious illness or disease.

When would I use it?
Think of the HSA as covering your "everyday" or even elective health & dental expenses, and for most people it will be all you ever use. But, if through illness or injury, you suddenly had expenses for expensive prescription drugs, prosthetic devices, medical devices, hospital or home nursing, for example, then you could use your Excess Medical Insurance to cover the cost.

What does it cover?
Excess Medical Insurance covers the expenses noted above. It does not cover any dental expenses or elective medical expenses (however, many of these are claimable under the HSA).

Are there any limitations?
Yes, there are two limitations or conditions you should be aware of:

First, Excess Medical Insurance only "kicks in" once your claims for Drug, Hospital or Private Duty Nursing, etc. have exceeded a deductible of $2,500 per person per calendar year.

Secondly, while no health evidence is required, **there is a 24 month waiting period for coverage of medications for pre-existing conditions.**

Note: these limitations apply **only** to the Excess Medical Insurance. **There is no deductible or waiting period for your HSA claims.**

C What happens to unused eHSA contributions at year end?

Unused contributions from the first plan year are not lost – they carry forward to the second plan year, and if not used by the end of that plan year are forfeited back to the employer, as per Revenue Canada rules.

D What if I already have benefit coverage through my spouse?

This is quite common, and the HSA actually works to your advantage when combined with any other group or individual coverage, because **you decide whether you wish claims to be claimed first against your HSA, or any other insured benefits** that you are also covered by, such as a spouse's program.

This flexibility is very useful, since **you can claim from your HSA any co-insurance amounts or deductibles** that you must pay out-of-pocket on the spouse's program.

enVia Benefits Program
P.O. Box 47509, 946 Lawrence Ave. East, Don Mills, ON M3C 3S7
416-446-0115 phone | **1-877-755-9670** toll-free | **416-446-7371** fax
www.envia.ca

enVia Health Spending Account Cost Summary – January 1, 2014

ALL PROVINCES

Net Annual Amount in Employee's HSA	Administration Fee incl. GST	EXCESS Medical Insurance & EAP Special Risk Premium/month + Applicable Taxes** (Mandatory)	Total Monthly Cost Per Person
$1,000 ($83.33/mo.)	$10.00/mo.	$16.74 Single $31.78 Couple $38.62 Family	$110.07 Single $125.11 Couple $131.95 Family
$1,500 ($125.00/mo.)	$15.00 mo.	As above	$156.74 Single $171.78 Couple $178.62 Family
$2,000 ($166.67/mo.)	$20.00/mo.	As above	$203.41 Single $218.45 Couple $225.29 Family
$2,500 ($208.33/mo.)	$25.00/mo.	As above	$250.07 Single $265.11 Couple $271.95 Family
$3,000 ($250.00/mo.)	$30.00/mo.	As above	$296.74 Single $311.78 Couple $318.62 Family
$4,000 ($333.33/mo.)	$40.00/mo.	As above	$390.07 Single $405.11 Couple $411.95 Family
$5,000 ($416.67/mo.)	$50.00/mo.	As above	$483.41 Single $498.45 Couple $505.29 Family
$6,000 ($500.00/month)	$60.00/mo.	As above	$576.74 Single $591.78 Couple $598.62 Family
$7,200 ($600.00/month)	$72.00/mo.	As above	$688.74 Single $703.78 Couple $710.62 Family
$10,000 ($833.33/month)	$100.00/mo.	As above	$950.07 Single $965.11 Couple $971.95 Family

** **Applicable Taxes:** No Tax on HSA as it is an individual Health plan under Ontario RST Act. RST applicable to Special Risk and Excess Medical as provided via a group policy. HST is applicable to EAP services.

E & O Excepted Maclagan Inc. December 2, 2013

If you have any questions or require assistance please contact: **www.enVia.ca**

John Maclagan at: 416-446-0115; email: jmaclagan@sympatico.ca OR Scott Maclagan at: 905-554-0875; email: scott@maclagan.ca

enVia Health Spending Account INDIVIDUAL EMPLOYEE Application Instructions

Welcome to the enVia HSA Benefits Program!

We know that filling out insurance applications can sometimes be confusing and complicated, so we've made every effort to simplify the process. Please use the following points to assist you in completing the necessary forms. They will help you to complete the application accurately and allow us to process your information as quickly as possible.

Under this Program, your employer contributes a "defined annual amount" to your enVia Health Spending Account (HSA). The key features of an HSA are

- The HSA is like a personal health and dental bank account that can be used to pay exclusively for medical and dental expenses, and other expenses not fully covered under other medical and dental plans.
- A much broader range of medical & dental expenses are claimable compared to a traditional group insurance program.
- You determine how to spend the available funds.
- You can also use the HSA to pay for expenses for financially dependent members of your extended family, such as your parents, your grandparents or your grandchildren, who are not normally eligible under medical or dental plans.

What kind of expenses can I claim from my HSA?

Probably a lot more than you'd think, and definitely a lot more than under any traditional group insurance plan. You'll find a listing of eligible expenses in the program flyer.

What if I don't spend all of the available funds in a given year?

It is important to budget your available HSA funds, and to seek the lowest cost medical or dental service provider. Any remaining positive HSA balance at the end of a policy year cannot be refunded, but will be carried forward to the next Plan Year. If not used by the end of the 2nd year, it is forfeited back to the contributing employer as per Canada Revenue Agency rules.

Which Forms do you need to complete?

You need to complete:

1. The attached **enVia Health Spending Account INDIVIDUAL EMPLOYEE Application Form**
2. The attached **enVia Chronic Conditions Reporting Form**

How to Complete the Application Form:

1. Fully complete the General Information Section. Please ensure that you provide an email address and phone numbers where you can be contacted if the Administrator requires additional information.
2. In Section 2 please provide details of your eligible dependents.
3. Under Section 3.1 please indicate the coverage required, i.e. **Single, Couple** or **Family**. (Couple can included a Single Parent w/1 child)
4. In Section 3.2 indicate the annual amount of your employer's contribution to your HSA.
5. Section 4 requires you to complete the **AD&D Beneficiary Designation** for the Special Risk Accidental Death & Dismemberment (AD&D) coverage.
6. Sign and Date the Application in Section 5, and forward it to the address indicated.

If you have questions, or require assistance, please contact us at one of the numbers below:

Telephone: (416) 446-0115 **Fax: (416) 446-7371** **E-mail: info@maclagan.ca**

enVia Health Spending Account INDIVIDUAL EMPLOYEE Application Form

1 Your General Information

YOUR NAME (LAST NAME / FIRST NAME / INITIAL)			MARITAL STATUS ◯ MARRIED ◯ SINGLE ◯ COMMON-LAW ◯ OTHER ____________	
DATE OF BIRTH (DD/MM/YYYY)	SEX ◯ MALE ◯ FEMALE	LANGUAGE ◯ ENGLISH ◯ FRENCH	PRIMARY OCCUPATION	HOURS PER WEEK (MINIMUM 20 HOURS)
HOME ADDRESS		CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE	WORKPLACE TELEPHONE		FAX	
EMAIL ADDRESS		DATE OF HIRE (MM/DD/YYYY)	EMPLOYMENT STATUS ◯ FULL-TIME ◯ PART-TIME	
EMPLOYER NAME	ADDRESS	CITY	PROVINCE	POSTAL CODE

2 Your Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	Child Aged 21-25 (or 25+ if Disabled)
Spouse:				
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED

If a Child is over age 21, state if a Student or Disabled. Students only covered up to age 25 and must provide proof of attendance at school (ie. a copy of their student card).

To maximize your HSA, claims should be submitted first to your spouse's benefit program, if applicable.

3 Your enVia Health Spending Account (HSA) Coverage (includes Excess Medical Insurance)

1. Please indicate your level of coverage: ◯ **Single** ◯ **Couple** (can include a Single Parent with 1 child) ◯ **Family**

2. Employer Annual HSA Contribution Amount:

Note: If you are completing the application as an employee, your contribution amount will have been pre-determined by your employer and the amount communicated to you.

Annual Amount Employer Contribution to HSA: $____

4 AD&D Beneficiary Designation:

◯ REVOCABLE ◯ IRREVOCABLE

BENEFICIARY(IES) SURNAME(S), GIVEN NAME(S) & INITIAL(S)____

RELATIONSHIP OF BENEFICIARY TO INSURED____________________ **If beneficiary is under age of majority, please complete TRUSTEE section**

I, the undersigned applicant, hereby appoint the person(s) stated as my beneficiary(ies) on my current and future insurance benefits and understand that I may, without restriction, change my beneficiary at any time in the future.

Applicant's Signature X____**Date**____________________

DECLARATION APPOINTING TRUSTEE (complete if beneficiary is under age of majority)

I do hereby appoint________________________as Trustee to receive any amount due to any beneficiary under the age of majority and declare receipt of such Trustee shall be in good discharge to the insurer for the amount so paid. And I hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at______________**this**______________**day of**______________________________**20**_____

Applicant Signature X______________________________**. You must also sign the Declaration & Authorization on the next page** >

5 Declaration & Authorization

I acknowledge that Personal Information collected with this Application for a Health Spending Account (including Excess Medical Insurance and Accidental Death & Dismemberment Insurance) is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that this application is for a Health Spending Account established in accordance with the Income Tax Act Interpretation Bulletins IT-339R2 & IT-529, and includes coverage for Excess Medical Insurance and Accidental Death & Dismemberment Insurance. It is administered by Esorse Corporation, a Pharmacy Benefits Manager and Third Party Administrator. Esorse will not be liable for any claims where the participant failed to provide complete and accurate information. I understand that claims must be submitted within 30 days of the end of a calendar year for the claims incurred in the prior year, and that unused funds carry forward for one year only and if not used then are forfeited to the contributing employer. The funds are held in a Trust Account by Esorse and no interest is credited. Unused funds cannot be returned to individual participants.

The Excess Medical Insurance is underwritten by the Western Life Assurance Company, and the Accidental Death & Dismemberment Insurance is underwritten by the AIG Insurance Company of Canada.

This program may be terminated at anytime by either party on 30 days written notice. This Application/Enrolment form together with the participant booklet constitutes the entire Agreement. No Agent, Broker or other person has authority to waived any condition of this Agreement.

Participants will be able claim up to the balance in their account at anytime and may access their account status online 24/7.

Signed at: ____________________, ________________ this _______ day of _________________, _____________ Applicant's Signature **X** ________________________________
CITY / TOWN PROVINCE DATE MONTH YEAR

Privacy & Confidentiality We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to the Insurer's or the Plan Administrator's Customer Service Dept., the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Mail or Fax your completed application to:

enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7

enVia
HEALTH SPENDING ACCOUNT

Phone: (416) 446-0115
Fax: (416) 446-7371
E-mail: info@maclagan.ca

PRIVATE & CONFIDENTIAL
Pre-Existing / Chronic Condition Reporting Form for Excess Medical Insurance

Purpose: To report confidentially any chronic or pre-exisiting conditions, treatments or medications.

Why: While participants are immediately covered for any eligible newly diagnosed conditions, treatments or medications, there is a 24 month waiting period from your effective date of coverage for any pre-existing or chronic conditions before those expenses will be covered / reimbursed under the Excess Medical Insurance Policy. **THIS ONLY APPLIES TO THE EXCESS MEDICAL INSURANCE - YOUR HEALTH SPENDING ACCOUNT STILL ALLOWS YOU TO CLAIM ANY ELIGIBLE EXPENSE FROM DAY ONE.**

Scope: This form should be completed both for the applicant and any eligible dependents.

Will reporting a condition have any impact whether or not I get approved? No, the plan is offered on a guaranteed issue basis. Reporting a pre-existing or chronic condition here only allows the administrator to determine the date after which your current medications / treatments will be covered / reimbursed under the Excess Medical Insurance Policy.

What will happen if I fail to report a pre-existing or chronic condition? Failure to disclose pre-existing or chronic conditions may result in the rejection of certain drug / treatment claims and / or termination of all coverage.

Will my employer be made aware of any information on this form? No, this form is strictly confidential. The information provided will be kept confidential and will not be shared with your employer or any party other than the Insurer and the Administrator, Esorse Corporation, the provider of the Pay-Direct Drug Card.

Name: ______________________________ Employer: ______________________________

Email: ______________________ Home Tel: ____________ Work or Mobile Tel: ____________

List Pre-Existing / Chronic Conditions	Medications being taken	Applies to (Self or Dependent's name)	Prescribing Physician's Name & Telephone Number

I certify the above information to be a full and complete disclosure of any and all of my or my dependent's pre-existing or chronic conditions of which I am currently aware and treatment has been received or counselled and/or for which medication or treatment has been prescribed or recommended. I agree that the Insurer or its Service Providers may, if necessary, contact my or my dependent's personal physician to determine the nature of a condition for which medication has been prescribed.

______________________________________ ______________________

(Signed) (Date)

Please retain a copy for your records and mail the completed form directly to:

PRIVATE & CONFIDENTIAL
enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7

Or FAX this form to: 416-446-7371

If you have any questions or require assistance please contact:

John Maclagan at: 416-446-0115; email: jmaclagan@sympatico.ca OR Scott Maclagan at: 905-554-0875; email: scott@maclagan.ca

ESORSE CORPORATION
234 Eglinton Ave. East, Suite 502
Toronto, ON M4P 1K5
Tel: 416-483-3265 Toll-free: 1-877-637-6773

Request for Pre-Authorized Withdrawal

Purpose:
This form is required to establish or make changes to the pre-authorized payments required for your insurance premiums or health spending account. You can choose to make payments via pre-authorized debit or charges to your credit card.

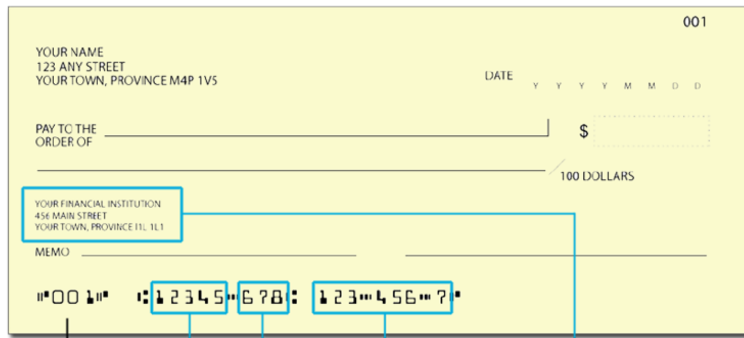
My Information:

Name: ____________ Company / Employer Name: ____________

Address: ____________ Phone: ____________

Email: ____________ I wish to pay by: ◯ Pre-Authorized Debit ◯ Credit Card

My Bank Information (if paying by Pre-Authorized Debit):
Using the sample cheque image as a guide, please provide the requested information to enable your monthly pre-authorized payments.



Bank Name: ____________

Branch Address: ____________

Bank Number: ____________

Transit Number: ____________

Account Number: ____________

If you are unsure of your banking information, please attach a copy of one of your cheques marked "VOID".

My Credit Card Information (if paying by credit card):

Card Type: ◯ VISA ◯ MASTERCARD

Name as it appears on card: ____________

Credit Card Number: ____________ Expiry Date: ____ / ____

Authorization Agreement:

I hereby authorize Esorse Corporation to make automatic withdrawals for my insurance premiums and/or health spending account, either from my account at the financial institution named below, or charged to the credit card specified below.

I understand that premiums will be withdrawn on the 28th of each month for the month following.

Further, I understand that Esorse Corporation will terminate my pre-authorized payment plan if any withdrawal is reversed by my financial institution, and that this form authorizes Esorse Corporation to charge a fee for any pre-authorized payments not honored by my financial institution.

This agreement will remain in effect until Esorse Corporation receives a written notice of cancellation from me, or until I submit a preauthorized withdrawal form.

Authorized Signature: **X**____________________ Date: ____________

Please complete & sign this form and fax it to: (416) 446-7371