enVia

Basic & Enhanced Plans

OUR LATEST

The **enVia Basic & Enhanced Plans** are the latest addition to our lineup of real-world, needs-related benefit programs. See them all at **envia.ca**

NO ANNUAL MAXIMUM

No overall annual benefit maximum for either plan (some benefits do have specific limits)

PAY-DIRECT DRUG CARD

Automatically included for quick & easy claims payment (up to plan limits)

NEEDED BENEFITS

Vision, Hearing, Health Supplies & Equipment including for Diabetics.

TRAVEL COVERAGE

Trips for 30 days or less, $2 million total coverage.

YOUR BUDGET: YOUR CHOICE

The new **enVia BASIC** and **ENHANCED Programs** have been developed to respond to the benefit needs of individuals & families looking for a lower cost program than others available in the marketplace. Both Programs are **available without any health evidence** and can include **Optional Dental Coverage.**

PLAN HIGHLIGHTS:

PRESCRIPTION DRUGS

80% reimbursement up to $750 or $1,000 per person, per policy year. Formulary and non-formulary. (24 month waiting period before prescription drugs for chronic pre-existing conditions are eligible for reimbursement)

PROFESSIONAL PRACTITIONERS

80% reimbursement up to $30 per visit to a combined maximum of $500 or $750 per person, per policy year. Includes: Acupuncture, Chiropody/Podiatry, Chiropractic, Clinical Psychology, Massage Therapy & Physiotherapy.

OPTIONAL DENTAL

80% reimbursement up to $700 for Basic & Preventative Services including examinations, x-rays, routine extractions & fillings and cleaning.

enVia BENEFITS PROGRAM

enVia Benefits Program

416-453-9430 phone | 1-877-755-9670 toll-free | 416-446-7371 fax | www.envia.ca | info@envia.ca

ENVIA BASIC AND ENVIA ENHANCED
Health Plan Options & Premiums

Health Benefits

Benefit	Basic 80% Reimbursement	Enhanced 80% Reimbursement
Health Practitioners	Up to $30 per visit to a combined maximum of $500 per person per year.	Up to $30 per visit to a combined maximum of $750 per person per year.
Vision (Enhanced Plan: 6 month waiting period before glasses/ contacts are eligible for reimbursement.)	$50 per person per 2 policy years for eye exams	$50 per person per 2 policy years for eye exams $200 per person per 2 policy years for glasses/ contacts
Hearing Aids	$500 per 5 years	$500 per 5 years
Diabetic Supplies & Equipment	$300 per person per policy year	$300 per person per policy year
Custom Made Foot Orthotics	$225 per person per policy year - combined with therapeutic shoes	$225 per person per policy year - combined with therapeutic shoes
Therapeutic Shoes	$225 per person per policy year - combined with custom made foot orthotics	$225 per person per policy year - combined with custom made foot orthotics
Ambulance	Up to $250 per trip 50% return for bedridden cases	Up to $250 per trip 50% return for bedridden cases
Preferred Hospital Rooms (excludes private hospital rooms)	N/A	$1,000 per person per policy year
Private Duty Nursing	N/A	$2,500 per person per policy year
Accidental Injury to Natural Teeth	$1,000 per injury	$1,000 per injury
Health Supplies & Equipment (wigs, splints, compressors, braces with metal parts, trusses, rib belts, sacroiliac corsets, embolic stockings, aero chambers and more)	$500 combined (4 pair of embolic (compression) stockings per policy year)	$500 combined (4 pair of embolic (compression) stockings per policy year)
Travel Coverage (unlimited number of trips)	Trips for 30 days or less, $2 million total coverage	Trips 30 days or less, $2 million total coverage
Prescription Drug Coverage (coverage per person per policy year; pay-direct card included with each option)	80% up to $750/person per policy year ($6 dispensing fee maximum)	80% up to $1,000 per person policy year ($8 dispensing fee maximum)

This is a summary only. Please refer to the policy booklet for complete details.

Health Premium *(per month)*

Coverage Type	Basic	Enhanced
Single	$60.86	$80.03
Couple	$112.91	$148.48
Family	$169.08	$222.34

Conditions & Exclusions to Coverage

Provision	Conditions & Exclusions	Details
Termination of Benefits	Age 70	
Dependant Coverage	Up to age 21 or age 25 if a student	• To be eligible for coverage as an over-age dependant, students must be undergoing full-time education training at an institute within Canada, subject to the state limitations stated in the policy wording. Over-age disabled dependants are also eligible.
Annual Deductible	None	

Dental Benefits *(coverage per person per policy year)*

Service	Coverage *($700 per year)*
Preventative	80%
Basic	80%

Dental Premium

Coverage Type	Per Month
Single	$37.52
Couple	$82.98
Family	$109.69

Preventative Services

- cleaning, scaling and polishing (6 month recall)
- topical fluoride treatment
- pit and fissure sealants
- occlusal adjustment and equilibration
- interproximal disking of teeth
- bruxism appliances

Basic Services

- examinations and dental x-rays
- routine extractions and fillings
- basic oral surgery performed by dentist, including anaesthesia
- root canal therapy
- denture repairs, relining and rebasing
- surgical and non-surgical periodontal treatment

Conditions & Exclusions to Coverage

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Annual Deductible	None	

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ENVIA BASIC & ENVIA ENHANCED
Enrolment Form

Completed applications, along with the a cheque for the first month's premium, must be received by GMS five business days before the requested effective date (must be the 1st of the month). All other applications will be processed to be effective the 1st of the month following the requested effective date. Please remember to include a Pre-Authorized Debit Agreement with this enrolment form.

A. Personal Information

ELIGIBILITY: Full & part-time, self-employed, contract, or casual workers working at least 20 hours per week (not available in Quebec). Coverage will be effective the first of the month following the date the application is received and accepted by GMS.

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*

Address	City	Province	Postal Code

Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ No

B. Coverage Selection

Health Plan

❑ Basic - Single ❑ Basic - Couple ❑ Basic - Family ❑ Enhanced - Single ❑ Enhanced - Couple ❑ Enhanced - Family

Dental Coverage *(only available with a health plan)*

❑ No Dental Coverage ❑ Dental - Single ❑ Dental - Couple ❑ Dental - Family

C. Family Information

	First Name	**Last** *(if different from yours)*	**Sex**	**Date of Birth** *(DD/MM/YYYY)*	**Provincial Health Care Coverage in Place?**	**Dependant age 21 or over?[2]**
Spouse[1]			❑ M ❑ F		❑ Yes ❑ No	N/A
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No

[1] If your spouse is common-law, please complete the following:

I have been living with and representing the above as my spouse since _____ *(DD/MM/YYYY)*. My common-law spouse and I are financially responsible for all our dependents claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

[2] For each dependant age 21 and over:

- in the case of a student dependant under age 25, please indicate the educational institution where the child is receiving full-time training:

  _____

- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

For Broker Use Only

Broker 1 MacLagan Inc.		Commission *(%)*
Broker 2	Code	Commission *(%)*

For Office Use Only: Coverage Effective Date

D. Other Coverage Information

Are you, your spouse or dependant(s) covered by any other insurance plan?

❑ Yes *(please complete the following)* ❑ No *(please skip to E)*

1	Name of Insured		Start Date of Coverage	End Date of Coverage *(if applicable)*
	Insurer	Policy No.	Certificate No.	Plan Type ❑ Group *(i.e. employer-sponsored)* ❑ Individual
	Coverage *(check all that apply)* ❑ Health ❑ Drugs ❑ Dental ❑ Vision ❑ Travel		Who Is Covered? *(check all that apply)* ❑ Me ❑ Spouse ❑ Dependants	
2	Name of Insured		Start Date of Coverage	End Date of Coverage *(if applicable)*
	Insurer	Policy No.	Certificate No.	Plan Type ❑ Group *(i.e. employer-sponsored)* ❑ Individual
	Coverage *(check all that apply)* ❑ Health ❑ Drugs ❑ Dental ❑ Vision ❑ Travel		Who Is Covered? *(check all that apply)* ❑ Me ❑ Spouse ❑ Dependants	

E. Declaration

I declare that the information given on this form is true and complete and shall form part of my application for coverage. I hereby authorize any health or dental care provider, other person, hospital or institution to release to GMS and/or their designated travel assistance representative(s) (collectively "GMS") any information covering my medical history, symptoms, treatment, examination, diagnosis and/or services rendered to myself or any of my dependants herein listed.

For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS: (a) to store and use any information which I have provided or information which it obtained pursuant to clause (b); and/or (b) to obtain information from, or disclose information to: my Government Health Insurance Plan; the operator of any hospital, clinic or other health care facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required.

I understand that whether before or after my application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void my coverage. I declare that, if I am signing on behalf of any person(s), I have the authority to sign on behalf of such person(s) and confirm that each of the above declarations and authorizations are also provided on behalf of such persons(s).

I warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein. Should I or any person herein listed subsequently obtain additional coverage through any insurer, while covered under this contract, I will immediately advise GMS in writing. I hereby authorize GMS to coordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Signatures of all family members over the age of 18	Date *(DD/MM/YYYY)*
X	

Please remember to include your Pre-Authorized Debit Agreement with this enrolment form.

PRE-AUTHORIZED DEBIT (PAD) Agreement

Please complete this PAD Agreement and return it, along with payment for the first month's premium, to: *Administration* at *Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.* The original signed form is required for pre-authorized debits to be authorized.

A. General Information

GMS ID No. *(if applicable)*	Group Plan No. *(if applicable)*	Date *(DD/MM/YYYY)*

Please indicate what type of use this PAD Agreement is for:

❑ Business *(I am an employer paying my employee's premium.)*

Employer Name

❑ Personal *(I am an individual paying my own premium.)*

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*

B. Account Information *(please include a void cheque with this agreement)*

Financial Institution Name	Address	
City	Province	Postal Code

Financial Institution ID Number	Branch Transit Number	Account Number
❑ ❑ ❑	❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

Type of Account *(only Canadian accounts are acceptable)*

❑ Savings ❑ Chequing

Is this a change to your PAD Agreement information? *If "Yes", please describe the reason for change.*

❑ Yes ❑ No

C. Declaration

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to begin deductions as per my/our ("my") instructions for monthly regular recurring payments, and/or one-time payments from time to time, for payment of all charges arising under my GMS account(s). Regular monthly payments for the full amount of services delivered will be debited from my account on the 1st ❑ or 15th ❑ *(choose one date only)*.

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided above at least 10 business days before the next debit is scheduled to be processed. Please contact our office or visit our website to obtain a cancellation form.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**X**
Name *(please print)*	Name *(please print)*

**Where Account Holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorized Debit Agreement.*

Please remember the following when using Pre-Authorized Debit:

- Payment for the first month's premium amount must be included with this application.
- You may be subject to an administration charge for each monthly withdrawal.
- Non-Sufficient Funds (NSF) withdrawals will be handled in accordance with GMS' standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration charge and GMS' standard NSF policy can be found on gms.ca.
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination of this PAD Agreement.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement at least 10 business days before the next debit is scheduled to be processed.