gsc healthassist®

LINK

Benefit & Coverage Details

Individual Health & Dental Plans

gsc green shield canada

If you need to switch from your current health plan to a new one …

GSC Health Assist LINK® offers guaranteed coverage for you and your family for day-to-day medical, dental and travel expenses, as well as unforeseen health expenses.

Time to make the LINK to the plan that's right for you …

Now you can make the LINK to the health plan that you and your family need – without all the hassles of trying to decipher what exactly the plan includes – or better yet, what it excludes. Even better still, applying for any of these Health Assist LINK plans is easy – you don't have to complete a medical questionnaire as long you apply within 90 days of your group insurance end date.

Just select the plan that best suits your needs. Make the LINK today.

Here's a description of some key LINK benefits…

PRESCRIPTION DRUGS

Prescription drug benefits cover prescription drugs approved for use in Canada that require a prescription by law and have been prescribed by an authorized medical practitioner.

Brand name drugs are covered if no generic equivalent exists.

Smoking cessation products and drugs for the treatment of obesity, infertility and erectile dysfunction are not covered.

DENTAL CARE

BASIC SERVICES:

- Preventive cleaning
- Routine examinations, x-rays
- Fillings and extractions
- Fluoride treatment for children

COMPREHENSIVE BASIC SERVICES:

- Endodontic treatment – root canal therapy
- Periodontal treatment – scaling and root planing, occlusal adjustment, equilibration
- Denture repairs, rebasing, relining

MAJOR SERVICES:

- Crowns and onlays, dentures, bridgework

ORTHODONTIC SERVICES:

- Orthodontic treatment to straighten teeth and correct the bite

EXTENDED HEALTH CARE

MEDICAL ITEMS:

- Aids for daily living (such as hospital style beds, IV stand, trapeze, bedpan)
- Braces, casts, catheters and ostomy supplies
- Compression stockings
- Diabetic supplies
- Custom made boots or shoes, custom made foot orthotics
- Mobility aids (such as canes, crutches, walkers, wheelchairs)
- Prosthetics
- Respiratory/cardiology items (such as breathing and heart monitors for infants, compressors, oxygen)

EMERGENCY MEDICAL TRAVEL COVERAGE

Emergency medical coverage when travelling out-of-province or out-of-country

HOSPITAL ACCOMMODATION

Semi-private and/or private accommodation in a public general hospital

Benefits effective April 1, 2020	No Medical Underwriting Required — Your Acceptance is Guaranteed			
	LINK Plan 1	**LINK Plan 2**	**LINK Plan 3**	**LINK Plan 4**
PRESCRIPTION DRUGS (benefits per person)				
Maximums	Year 1: $500 Year 2: $650 Year 3+: $800 Plan pays 80% subject to annual max.	Year 1: $750 Year 2: $900 Year 3+: $1,100 Plan pays 80% subject to annual max.	Year 1: $1,200 Year 2: $1,350 Year 3+: $1,500 Plan pays 80% subject to annual max.	Year 1: $2,300 Year 2: $2,400 Year 3: $2,500 Year 4+: $2,700 Plan pays 80% subject to annual max.
DENTAL CARE (benefits per person)				
Maximums	Not included	Year 1: $600 Year 2: $800 Year 3+: $1,000	Year 1: $750 Year 2: $1,000 Year 3+: $1,250	Year 1: $1,000 Year 2: $1,250 Year 3+: $1,750
Recall Frequency		9 months	9 months	6 months
Basic Services		Plan pays 80%, subject to annual max.	Plan pays 80%, subject to annual max.	Plan pays 80%, subject to annual max.
Comprehensive Basic Services		Plan pays 80%, subject to annual max.	Plan pays 80%, subject to annual max.	Plan pays 80%, subject to annual max.
Major Services		Not included	Available in Year 3 - Plan pays 50%, subject to annual max.	Available in Year 3 - Plan pays 60%, subject to annual max.
Orthodontic Services		Not included	Not included	Available in Year 3 - Plan pays 60% to lifetime max. of $2,000
VISION CARE (benefits per person)				
Vision Care Prescription eyeglasses, contact lenses, laser eye surgery	$150 every 2 years	$200 every 2 years	$250 every 2 years	$300 every 2 years
Eye Examination	$50 every 2 years	$50 every 2 years	$65 every 2 years	$80 every 2 years
EXTENDED HEALTH CARE (benefits per person)				
Professional Services/Registered Therapists				
Chiropractor, Chiropodist/Podiatrist, Naturopath, Osteopath, Physiotherapist	$20 per visit, 15 visits per practitioner, per year	$300 per practitioner, per year	$400 per practitioner, per year	$600 per practitioner, per year; up to $1,200 per year combined
Massage Therapist, Acupuncturist	$20 per visit,15 visits per practitioner, per year	$20 per visit, 15 visits per practitioner, per year	$20 per visit, 20 visits per practitioner, per year	$30 per visit, 20 visits per practitioner, per year
Psychologist/Registered Social Worker	$600 per year, combined	$600 per year, combined	$600 per year, combined	$600 per year, combined
Speech Therapist	$300 per year	$300 per year	$400 per year	$600 per year
Accidental Dental	$2,500 per year	$5,000 per year	$10,000 per year	$10,000 per year
Ambulance Transportation	Includes land and air	Includes land and air	Includes land and air	Includes land and air
Hearing Aids	$300 every 4 years	$400 every 4 years	$500 every 4 years	$600 every 4 years
Medical Services Diagnostic tests and x-rays, dialysis equipment, laboratory tests	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
Medical Items and Home Support Services (in home nursing) Separate maximums for Medical Items and Home Support Services	$1,500 per benefit category, per year	$2,500 per benefit category, per year	$5,000 per benefit category, per year	$5,000 per benefit category, per year
HOSPITAL ACCOMMODATION (benefits per person)				
Semi-Private and/or Private Benefit pays the difference between standard ward charges and semi-private and/or private accommodation in a public general hospital	$200 per day 30 days max. per year	$200 per day 30 days max. per year	$200 per day 30 days max. per year	$250 per day 30 days max. per year
TRAVEL (benefits per person)				
Emergency Medical Travel Coverage Out of Province/Country	10 days per trip $5,000,000 per year	10 days per trip $5,000,000 per year	15 days per trip $5,000,000 per year	15 days per trip $5,000,000 per year

Additional information

This Plan Comparison is a summary and does not constitute a contract. Actual terms, conditions, limitations and exclusions are detailed in the contract issued by GSC upon application approval.

No medical underwriting is required as long as you apply within 90 days of your group coverage end date. Your acceptance for LINK plans is guaranteed upon GSC's receipt of your initial payment.

Reimbursement will be made for eligible expenses incurred, paid for and received by the covered person provided such services and supplies are, in the opinion of GSC, medically necessary for the treatment of an illness or injury and reasonable and customary, taking all factors into account.

Quebec residents: To be eligible for LINK prescription drug coverage, you must be covered by the RAMQ prescription drug plan. Your prescription drug claims must be submitted to RAMQ first. When RAMQ reimburses a portion of the drug cost, the unpaid balance (including co-payment and deductible) will be co-ordinated so that you may be reimbursed up to 100% of the eligible expense incurred. If the drug is not covered by RAMQ, the standard co-pay applies

Coverage amounts shown are in Canadian Dollars.

Rates and/or benefits are subject to change; GSC will provide plan members with thirty (30) days written notice.

Plans provided by

Green Shield Canada (GSC).

Green Shield Canada, 8677 Anchor Drive, PO Box 1606, Windsor, ON N9A 6W1

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HA-LINK-PlanComp-N.E.01/20

LINK plans offer valuable coverage at competitive prices

GSC Health Assist LINK® plans are designed to cover the gaps in your provincial health insurance plan. Since provincial plans differ from province to province, LINK rates vary depending on where you live.

There are three LINK rate categories…

Single: applies to applicant only.

Couple: applies to applicant and spouse/partner **OR** applicant and one dependent child under age 21.

Family: applies to applicant and spouse/partner and dependent children under age 21.

Some additional details to note…

Rates are effective April 1, 2020.

Rates and/or benefits are subject to change; GSC will provide plan members with thirty (30) days written notice.

Rates are based on age of the primary applicant at the time of application. Rates will increase as an individual's age increases in accordance with published age bands.

Plans provided by

Green Shield Canada (GSC).

Green Shield Canada, 8677 Anchor Drive, PO Box 1606, Windsor, ON N9A 6W1

HA-LINK-RATES-N.E.01/20

gsc healthassist® LINK

Rates

Individual Health & Dental Plans

Effective April 1, 2020

Monthly Rates for Residents of:

	LINK Plan 1			LINK Plan 2			LINK Plan 3			LINK Plan 4		
	AGE	Single	Couple	Family	AGE	Single	Couple	Family	AGE	Single	Couple	Family	AGE	Single	Couple	Family
British Columbia	**18 - 44**	$80	$149	$209	**18 - 44**	$141	$263	$380	**18 - 44**	$173	$324	$478	**18 - 44**	$208	$389	$570
	45 - 54	$100	$183	$256	**45 - 54**	$158	$292	$416	**45 - 54**	$191	$357	$528	**45 - 54**	$243	$449	$665
	55 - 64	$108	$198	$280	**55 - 64**	$170	$311	$437	**55 - 64**	$209	$395	$580	**55 - 64**	$263	$498	$728
	65+	$93	$170	$229	**65+**	$137	$252	$354	**65+**	$183	$336	$478	**65+**	$228	$422	$603
Alberta	**18 - 44**	$80	$149	$209	**18 - 44**	$144	$267	$391	**18 - 44**	$170	$318	$468	**18 - 44**	$203	$380	$559
	45 - 54	$100	$183	$256	**45 - 54**	$160	$296	$421	**45 - 54**	$187	$348	$516	**45 - 54**	$235	$437	$653
	55 - 64	$108	$198	$280	**55 - 64**	$172	$316	$450	**55 - 64**	$204	$382	$566	**55 - 64**	$256	$481	$712
	65+	$93	$170	$229	**65+**	$139	$259	$360	**65+**	$174	$321	$457	**65+**	$218	$402	$575
Saskatchewan, Manitoba, Northwest Territories, Yukon and Nunavut	**18 - 44**	$79	$145	$203	**18 - 44**	$123	$227	$328	**18 - 44**	$162	$295	$435	**18 - 44**	$219	$407	$596
	45 - 54	$93	$175	$246	**45 - 54**	$133	$252	$356	**45 - 54**	$185	$345	$502	**45 - 54**	$255	$477	$697
	55 - 64	$104	$187	$264	**55 - 64**	$143	$266	$376	**55 - 64**	$204	$380	$555	**55 - 64**	$281	$524	$765
	65+	$86	$158	$210	**65+**	$114	$210	$294	**65+**	$148	$276	$389	**65+**	$200	$372	$526
Ontario	**18 - 44**	$95	$174	$243	**18 - 44**	$160	$298	$432	**18 - 44**	$186	$350	$512	**18 - 44**	$218	$409	$598
	45 - 54	$114	$211	$296	**45 - 54**	$175	$331	$467	**45 - 54**	$206	$387	$562	**45 - 54**	$256	$477	$697
	55 - 64	$125	$230	$329	**55 - 64**	$190	$351	$496	**55 - 64**	$227	$423	$616	**55 - 64**	$279	$523	$763
	65+	$107	$195	$265	**65+**	$155	$285	$395	**65+**	$194	$355	$511	**65+**	$245	$452	$643
Quebec	**18 - 44**	$87	$162	$229	**18 - 44**	$146	$269	$383	**18 - 44**	$186	$341	$505	**18 - 44**	$208	$384	$571
	45 - 54	$107	$197	$278	**45 - 54**	$161	$296	$421	**45 - 54**	$217	$400	$590	**45 - 54**	$243	$456	$668
	55 - 64	$119	$215	$308	**55 - 64**	$173	$315	$444	**55 - 64**	$237	$439	$649	**55 - 64**	$270	$500	$733
	65+	$114	$209	$286	**65+**	$159	$290	$405	**65+**	$204	$379	$537	**65+**	$258	$480	$685
New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador	**18 - 44**	$95	$174	$243	**18 - 44**	$144	$267	$390	**18 - 44**	$174	$328	$475	**18 - 44**	$209	$386	$563
	45 - 54	$114	$211	$296	**45 - 54**	$162	$299	$417	**45 - 54**	$193	$362	$529	**45 - 54**	$240	$453	$661
	55 - 64	$125	$230	$329	**55 - 64**	$172	$318	$452	**55 - 64**	$211	$396	$579	**55 - 64**	$263	$494	$723
	65+	$107	$195	$265	**65+**	$141	$262	$362	**65+**	$180	$336	$472	**65+**	$237	$444	$628

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LINK

Please complete SECTIONS A,B,C, D and E.

Application for **LINK** Health Coverage

Green Shield Canada (GSC)

SECTION A — Contact Information

Last Name:	First Name:	Initial:
Street Address:		Apt. No:
City/Town:	Province:	Postal Code:
Home Tel: ( )	Business Tel: ( )	Cell: ( )

***Email Address** (so GSC can contact you quickly about your application and benefits):

SECTION B — Coverage Information

I declare that I, and my spouse/partner and all listed dependents are covered by our provincial government health plan.

I/We are applying for:

- ☐ **Single coverage** *Applies to applicant only*
- ☐ **Couple coverage** *Applies to applicant and spouse/partner* **OR** *applicant and one dependent child under age 21*
- ☐ **Family coverage** *Applies to applicant and spouse/partner and dependent children under age 21*

A: Are you covered, or were you covered under a group health plan? ☐ **Yes** ☐ **No**

B: When does or did your coverage end? (YYYY/MM/DD):

C: Name of insurance carrier:

.....

Select one plan option:

- ☐ **LINK 1**
- ☐ **LINK 2**
- ☐ **LINK 3**
- ☐ **LINK 4**

Total Monthly Rate:

$

SECTION C — Individuals to be Covered — please complete in full for EACH person

Last Name	First Name	Initial	Gender	Date of Birth (YYYY/MM/DD)	Age
Applicant:			☐ Male ☐ Female		
Spouse/Partner:			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		
Dependent Child: *(must be under age 21)*			☐ Male ☐ Female		

Note: If additional space is required, please attach a separate signed and dated sheet.

Please proceed to complete SECTIONS D and E.

FOR ADVISOR USE ONLY

Advisor Code:	Advisor Name (first and last):	Advisor Email Address:
Office Code:	Office Name:	Advisor Telephone Number:
MGA Code:	MGA Name:	

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Plans provided by **Green Shield Canada (GSC).**

Reminder: BOTH Payment Authorization AND Declaration sections must be signed.

SECTION D — Payment Information (Applications without payment cannot be processed)

Your first payment for one month's premium will be taken when your application is approved. The next payment (for one month's premium) will be taken on or about your coverage start date (your coverage effective date), depending on the day of the week the first of the month falls. This ensures your payments (and benefits!) are secure a month in advance. Subsequent payments are taken on or around the first of every month. You can begin using your Health Assist benefits on your coverage effective date. Questions about payments? Call 1.800.268.6613, ext. 4460.

Choose ONE Method of Payment

☐ **Pre-authorized Credit Card** ☐ Mastercard ☐ Visa ☐ American Express

Name (as it appears on card): Credit Card Number: Expiry:

Address: City/Town: Province: Postal Code:

☐ **Pre-authorized Debit** PLEASE ATTACH A SPECIMEN CHEQUE MARKED "VOID"

Is this account Personal or Business? ☐ Personal ☐ Business

Is this a joint account? ☐ Yes ☐ No If "Yes", does this joint account require more than one signature? ☐ Yes ☐ No

If two signatures are required, information for both Account Holders must be provided:

1st Account Holder	2nd Account Holder
Name:	Name:
Address:	Address (if different from 1st payor):
City/Town: Province: Postal Code:	City/Town: Province: Postal Code:
Telephone Number: ( )	Telephone Number: ( )

Payment Authorization

I/We understand that I/we have certain recourse rights if any debit does not comply with this agreement and that I/we may obtain a Reimbursement Claim form, or for more information regarding our recourse rights, I/we may contact either our financial institution or visit www.payments.ca. I/We hereby authorize GSC to withdraw payments from the account specified above on or about the first business day of the month as outlined above. Should there be any change in either the amount payable or in the date payments are to be withdrawn, GSC will give the applicant written notice at least thirty days prior to the change. GSC may terminate coverage in the event that a withdrawal is refused for any reason and the financial institution shall not be held liable in any way should such an event occur. I/We understand that this authorization shall remain valid unless written notice requesting cancellation by the applicant or account holder(s) is received by GSC at least ten business days prior to the next pre-authorized payment due date. I/We further understand that a sample cancellation form and/or more information on my/our right to cancel a pre-authorized payment agreement can be found at my/our financial institution or by visiting www.payments.ca. I/We represent and warrant that the payment information provided above is complete and accurate and I/we will promptly notify GSC of any changes in such information and all persons required to authorize withdrawals from the account specified above have authorized the debits to be drawn from the specified account pursuant to this application.

X **Signature(s) Required:**

Signature of Account Holder: ..... Date (YYYY/MM/DD): .....

2nd Signature (if joint account): ..... Date (YYYY/MM/DD): .....

SECTION E — Declarations and Authorizations — ALL APPLICANTS MUST SIGN

NOTE: This authorization must be signed by the applicant and spouse/partner (if applicable). The information provided on this form is confidential.

By signing this application form, I/we agree that the statements contained herein are true and complete and form the basis for any coverage approved.
I am authorized to release information concerning my spouse/partner and/or dependent children, for the purposes of determining their eligibility for benefits. I/We understand that failure to disclose or falsifying information regarding my health and/or that of my spouse/partner and/or dependent children could result in denial of a claim and the cancellation or modification of this coverage. I/We authorize any physician, dentist, medical practitioner, hospital, clinic or other medical or medical related facility, insurance company, or other organization, institution or person that has any records or knowledge of my health, or that of my spouse/partner or any listed dependent children, to exchange such information as is needed to administer benefit claims, to provide access to other GSC services, and/or to confirm the accuracy of the information with GSC. I/We acknowledge that all information provided to GSC may be shared with the licensed advisor connected with this application for the purposes identified above, and for policy administration purposes. I/We understand that my/our personal information may also be shared with GSC service providers that require this information to perform their services, as is reasonably necessary, for the purposes identified above. Additional information on GSC's privacy policies and procedures is available online at www.greenshield.ca.
A reproduction of this consent and authorization shall be as valid as the original.

X **Signature(s) Required:**

Signature of Applicant: ..... Date (YYYY/MM/DD): .....

Signature of Spouse/Partner: ..... Date (YYYY/MM/DD): .....

ADVISOR'S REPORT – For Advisor/Agent Use Only

I confirm that I have disclosed the following information to the applicant: the name of the company or companies I represent; that I receive commissions for the sale of health and dental products and may receive bonuses or other incentives; and any conflicts of interest I may have with respect to this transaction.

Advisor Name (first and last):	Advisor Code:	X Advisor Signature:

Please send applications to GSC, Individual Products Team, 5140 Yonge St., Suite 2100, Toronto, ON M2N 6L7