PENSIONER'S POST RETIREMENT BENEFITS HANDBOOK
[HEALTH PLAN]

** The costs of coverage can be found on the main page of Pensioner's Corner*

Last updated October 2025

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Health plan

The **Concordia Health Plan** helps you and your insured eligible dependents manage the cost certain health-related expenses, in the event of illness or injury.

While the plan covers a wide range of services and treatments, some exclusions and limitations apply.

If you anticipate any unusual expenses or costs that aren't listed among the eligible expenses, it is important that you contact **Sun Life Financial** beforehand to confirm whether they'll be covered.

And remember, the best prescription for good health is prevention. Eat well, stay active, and take care of yourself everyday.

Highlights

Current coverage	
Deductible	$3 per prescription with a Drug Identification Number (DIN)
Percentage reimbursed subject to the deductible and certain limits:	
RAMQ drugs	80% (or 100% once annual eligible drug expenses exceed $3,000 per family in a benefit year)*
Non-RAMQ drugs	60% (or 100% once annual eligible drug expenses exceed $3,000 per family in a benefit year)*

*Note: for each benefit year, the Plan provides that, once the combined expenses for RAMQ and Non RAMQ drugs reach $3,000, such expenses will be reimbursed at 100% for the rest of the benefit year.

Percentage reimbursed *NOT* subject to the deductible but subject to certain limits:

Paramedical and other medical services	80%, maximums apply
Psychologists, psychiatrists and psychotherapists	80%, maximums apply
Audiologists and speech therapists	80%, maximums apply
Vision Care (if applicable)	80%, maximums apply
Emergency care and travel assistance outside your province of residence	100% (maximum 180 days of travel)
Hospital care (semiprivate room in a public general hospital or a licensed convalescent hospital)	100%
Emergency care and travel assistance:	$3 million lifetime maximum per insured person
All other eligible expenses combined:	$1 million lifetime maximum per insured person**

This annual eligible expense maximum of $3,000 does not apply to:

- Paramedical and medical services;
- the services of psychologists, psychiatrists and psychotherapists;
- vision care; and
- audiologists and speech therapists

** Should this maximum be reached, the plan will, however, continue to reimburse prescription drugs on the RAMQ list.

Please refer to the Eligible expenses section for a list of various covered expenses under each type of service as well as the Exclusions and limitations section.

Health Care Spending Account (HCSA)

The HCSA is an annual allowance to be used as needed to reimburse medical and dental expenses not covered or partially covered by the plan. The additional flexibility from the HCSA will enable you to get reimbursements for the care you need. Every year on January 1, the University will deposit the amount you are entitled to in your HCSA. The amount you are entitled to, is per certificate (you and your eligible dependents under the Health Plan) and will depend on your category of coverage under the Health Plan and your age (whether you are under or over age 65) as of January 1st of each year.

Examples of eligible HCSA expenses: Health care premiums,Eye exams glasses, Dental care, including orthodontics, Paramedical services, Medical equipment, Private hospital room.

Key players

There is a lot more to a health plan than simply reimbursing expenses.

Behind the scenes, several individuals are involved in the ongoing operations of the plan. Here are some of the key players.

Pension & Benefits Services

Pension & Benefits Services is staffed by qualified Human Resources specialists who work with the Benefits Committee and the insurance company.

The person responsible for the group insurance plans is:

Tania Lacroix
Manager, Pension & Benefits Services
T. (514) 848-2424 ext. 3661 F.
(514) 848-2844
tania.lacroix@concordia.ca

By mail:
FB 1130
Concordia University
1455 de Maisonneuve Blvd. W. Montreal, Québec H3G 1M8

Employee Services

Employee Services is staffed by Human Resources employees who work with employees and pensioners in the plan's day-to-day transactions.

Employee Services can be reached at:
By e-mail: hr-employeeservices@concordia.ca
By fax: (514) 848-2844

By mail:
FB 1130
Concordia University
1455 de Maisonneuve Blvd. W. Montreal, Québec H3G 1M8

In person
1250 Guy St, FB 1130

Benefits Committee

The Benefits Committee consists of employee and employer representatives. As far as the pension plan is concerned, the Benefits Committee is responsible for:

- reviewing the pension plan; and
- recommending plan changes to the Board of Governors.

The current members of the Benefits Committee are:

Academic Staff representatives

- Dr. Ciprian Alecsandru
- Dr. Shelley Reuter

Administrative and Support Staff representatives

- Ms. Faith Howard
- Mr. Brian Cooper

Part-time Employee Groups' representative

- Ms. June Riley (acquires voting rights in the absence of any of the Academic Staff and Administrative and Support Staff representatives)

Non-active Members' representative

- Dr. Jamshid Etezadi
- Alternate member: Ms. Amely Jurgenliemk

You can reach these members via the Secretary of the Committee

Members of the Board of Governors and University representatives

- Mr. Jeff Bicher, Chair; Member, Board of Governors
- Ms. Hélène Fortin, Vice-Chair; Appointed by the Board of Governors
- Mr. Michael Di Grappa; Vice-President, Services and Sustainability
- Ms. Caroline Jamet; Appointed by the Board of Governors
- Ms. Kathleen Lizé; Designated by the President and Vice-Chancellor
- Me Frederica Jacobs (non-voting); Designated by the Chair of the Board of Governors

You can reach these members via the Secretary of the Committee

Secretary of the Committee

- Mr. Marc Gauthier
  Secretary, Benefits Committee
  Concordia University
  1455 de Maisonneuve Blvd. West
  GM-700
  Montréal, Québec
  H3G 1M8
  Tel. : (514) 848-2424 ext. 5737
  Fax : (514) 848-8626
  benefitscommittee@concordia.ca

Sun Life Financial

The University has given Sun Life Financial the contract to underwrite and administer the Concordia Health Plan for a fee.

Under guidance from the Benefits Committee and Benefits Services, Sun Life Financial "manages" our account and assumes the risk for claims that exceed predetermined limits.

You

You, the user of the plan, also play an important role. How you use the plan directly affects the cost of the plan.

Government

The government plays a role to the extent that it introduces legislation or adopts policies that may affect your health coverage.

The government also provides a provincial health plan, which the Concordia Health Plan complements. However, should the government reduce or eliminate its coverage, Concordia will not necessarily modify its plan or cover any additional expenses. The Benefits Committee will review the scope of coverage periodically.

Eligibility & enrolment

You are eligible to participate in the Concordia Health Plan if you are:

- a member of an eligible employee group;
- a resident of Canada who is covered under a provincial health insurance plan or is designated as a non-resident status employee in Québec;
- one of the following:
    - a permanent employee; or
    - a pensioner (that is, someone receiving a pension from the Concordia Pension Plan) who was covered under the Concordia Health Plan immediately before retirement.

Your spouse and dependent children are also eligible.

Special rules if you are a Québec resident under age 65

If you retire from active service with Concordia and you are under age 65, the following will apply depending on whether you remain in Québec.

If you remain a Québec resident ...

Québec law requires that you continue your coverage under the Concordia Health Plan, unless:

- you are covered under another group health insurance plan, such as your spouse's plan where he or she works; or
- you are NOT considered an eligible pensioner.

If you reside outside Québec ...

If you are an eligible pensioner, you may make a **one-time choice** to continue to participate in the Concordia Health Plan **or to opt out.**

If you opt out, your decision will be **irrevocable**, that is, you will not be eligible to participate in the Concordia Health Plan at any future date. The only exception to this is if:

- you opted out because you were covered under another group health insurance plan elsewhere, such as your spouse's plan where he or she works (and proof of that coverage was provided to Benefits Services at the time you opted out); and
- you subsequently lose that coverage. In this case, you may join the Concordia Health Plan anytime within 31 days of the date your coverage ceases under the other plan. You will need to provide proof of the loss of coverage to establish your eligibility under the Concordia Health Plan.

Special rules if you are a Québec resident age 65 or over

Before and during retirement, if you are age 65 or over, and live in Québec, you can choose to have the drugs that appear on the formulary of the Régie de l'assurance-maladie du Québec (RAMQ), covered under:

- the provincial government's universal drug plan; or
- under a group insurance plan such as Concordia's (the University will require that you pay an additional premium).

Certain provisions apply.

Note: This age requirement applies only to you, not to your spouse. As a result, if you are age 65 or over, the above rules will apply regardless of your spouse's age. Also, if you are under age 65 but your spouse is age 65 or over, the Concordia Plan will continue to cover RAMQ drugs.

For coverage of other eligible expenses, we recommend that you remain with the Concordia Health Plan. Your choice of plan for drug coverage does not affect your coverage of other eligible expenses under the Concordia Health Plan.

If you opt out of the Concordia Health Plan, however, you cannot rejoin at a later date

Please note that you cannot add dependents who:

- were acquired after you retire; or
- were not eligible dependents when you retired

Special rules if you do not reside in Québec and you opt out

If you are a pensioner residing outside Québec and you opt out of the Concordia Health Plan, you cannot rejoin at a later date.

Categories of coverage

You have 2 categories of coverage to choose from:

1. Single (you alone)
2. Family (you, your spouse and/or dependent children)

Remember, regardless of whether you are an active employee or a pensioner, the category you choose must reflect your actual family situation, unless you provide written proof of duplicate coverage elsewhere.

The cost of coverage varies by category of coverage. If you reside in Québec, you may want to consider the tax implications of your choice of coverage.

Opting out

Once enrolled in the Concordia Health Plan, you and your eligible dependents will not be allowed to opt out at a later date, unless you obtain duplicate coverage elsewhere or unless you are age 65 or over.

Also note that, by law, your spouse and dependent children **must enroll in the provincial drug plan** if:

- you are 65 or over; and
- you are covered under the provincial drug plan.

If you already have coverage under a health plan where your spouse works or as a pensioner from a prior employer, you may choose not to participate in the Concordia Health Plan. If so, you must provide satisfactory proof of duplicate coverage.

If you reside in Québec and coverage under your spouse's plan or your prior employer's plan ends, provincial law requires that you and your eligible dependents join the Concordia Health Plan.

How the health plan works

Deductible

The deductible is essentially the amount that you pay per prescription before the plan starts to reimburse eligible prescriptions up to certain limits.

This deductible applies to prescription with a Drug Identification Number only. If you take prescription drugs on a regular basis to treat stable medical conditions, **ask your pharmacist for a renewal every 90 days instead of 30 days**. In addition to limiting your pharmacy visits, you will save on the deductible and the pharmacist dispensing fees.

By paying the deductible, you share in the cost of claims, and you help yourself reduce the premiums for yourself and all other participants.

Amounts reimbursed

The Health Plan reimburses eligible expenses incurred for the following types of services:

Amounts reimbursed subject to the deductible and certain limits:

	Percentage of reimbursement
RAMQ drugs	80% (or 100% once these annual eligible drug expenses exceed $3,000 per family in a benefit year)*
Non-RAMQ drugs	60% (or 100% once these annual eligible drug expenses exceed $3,000 per family in a benefit year)*
Acupuncturist, chiropodist, chiropractor, kinesiologist, massage therapist, naturopath, occupational therapist, osteopath, physical rehabilitation therapist, physiotherapist, podiatrist and sports therapist	80%, up to a combined maximum of $1,000 per benefit year
Psychologists, psychiatrists and psychotherapists	80%, up to a combined maximum of $1,500 per benefit year
Audiologist and speech therapist	80%, up to a combined maximum of $1,000 per benefit year
Vision care (if applicable)	80%, 1 eye exam every 24 months with a combined maximum of $160 (12 months for children under the age of 18)
Emergency care and travel assistance outside your province of residence	100% (maximum 180 days of travel)

	Percentage of reimbursement
Hospital care (semiprivate room in a public general hospital or a licensed convalescent hospital)	100%
Emergency care and travel assistance:	$3 million lifetime maximum per insured person
All other eligible expenses combined:	$1 million lifetime maximum per insured person (No limit for drugs on RAMQ list)

Note: for each benefit year, the Plan provides that, once the combined expenses for RAMQ and Non RAMQ drugs reach $3,000 such expenses will be reimbursed at 100% for the rest of the benefit year.

Please refer to the Eligible expenses section for a list of various covered expenses under each type of service as well as the Exclusions and limitations section.

Maximum lifetime reimbursement

The current maximum lifetime reimbursement for emergency care and travel assistance is $3 million per insured person.

All other eligible expenses are reimbursed up to a lifetime maximum of $1 million per insured person.

However, by law, since January 1, 1997, if you live in Quebec and reach the maximum lifetime reimbursement, the plan will continue to reimburse prescription drugs on the formulary of the Regie de l'assurance-maladie du Quebec (RAMQ), without limit.

Cost of coverage

Please consult Pensioner's Corner main page for current rates

How costs are determined

Who determines that cost?

In reality, it's not the insurance company. It's not the University. It's YOU.

That's right. The premiums that both you and the University pay are based on the claims paid out to employees and pensioners each benefit year. So, how much participants and their families actually use the plan in any given benefit year will determine increases or decreases in benefit premiums at each renewal of the plan.

The plan essentially operates like a bank account:

1 Both you and the University make contributions (deposits) to the plan's account.

2 Whenever a claim is paid, the amount is deducted (withdrawn) from the account balance.

3 At the end of the benefit year—just as in a bank account—there has to be enough money in the account to pay not only all the claims made against it, but also the insurance company's expenses to administer the plan.

As a result, the insurance company sets premiums in consultation with the University, according to the expected cost of the plan for the coming benefit year as well as the anticipated use of the various plan benefits according to the "plan experience" shown in the past. The Benefits Committee must approve any changes in premiums.

From this perspective, it is easy to understand how we all have a certain responsibility, and ability, to help control expenses.

The Benefits Committee, for example, may periodically make plan changes or adopt various means (such as the drug card) to maintain a fair balance between cost and coverage.

Since you share in the cost of the plan, you also have a vested interest in making sure that the plan remains affordable and competitive. Some factors that affect the cost of claims are beyond everyone's control:

- continually rising inflation in the health sector, in large part due to the increasing cost of drugs and the arrival of new, more expensive drugs;
- new medical technology and an aging workforce, leading to a growing utilization of the Concordia Health Plan; and
- the ongoing shift of health care expenses from government plans to private plans.

What is taxable

If you are a Québec resident, the premium (including the sales tax) that Concordia pays toward your coverage under the plan is considered a taxable benefit. **However**, you may be able to deduct the following health care expenses when you file your income tax return:

Tax deductions on your...

	Québec income tax return	**Federal income tax return**
The premium (including the sales tax) that Concordia pays toward your coverage under the plan	No	No
The premium (including the sales tax) that you pay toward your coverage under the plan	Yes	Yes
Any medical and dental expenses eligible under the Income Tax Act that are not covered (in full or in part) by any plan	Yes	Yes

Eligible expenses

The following provisions apply for the plans you are eligible to participate in if you are a full- time employee, part-time faculty or a continuing education instructor. However, if you are a part- time employee covered by the RAMQ Drug Plan Equivalent, you are covered for the drugs listed on the RAMQ formulary; for more details, go to the government plan site.

The Concordia Health Plan covers a wide range of eligible expenses for:

- prescription drugs;
- hospital services; and
- certain medical and paramedical treatments and supplies not covered by the provincial health plan.

Eligible expenses are those that are deemed to be the **usual and prevailing** charges for the services listed below in the area in which they are incurred.

All services and supplies must be **medically required and recommended by a licensed physician**, except where indicated otherwise.

If you are not sure whether or not the plan covers a certain expense, please verify with Sun Life Financial beforehand. The insurer, not Concordia, is responsible for applying the terms of the insurance policy and is in the best position to answer your questions regarding health care coverage. If you have questions on health care, please consult your doctor.

Drugs *(after deductible, reimbursed at various levels)*

Drugs covered by the Concordia Health Plan

The following drugs are eligible for reimbursement under the plan:

- Drugs for treatment of an illness or injury, prescribed by a physician or dental surgeon, and dispensed by a pharmacist, including those for the treatment of cardiac problems, pulmonary problems, blood stream disorders (blood clot), cholesterol, digestive problems, infected wounds (cutaneous ulcer), diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis, glaucoma and hyperthyroidism. Homeopathic preparations are not covered.
- Compounded drugs, where one of the ingredients is an eligible drug expense.
- Oral contraceptives prescribed by a physician.
- Injectable drugs and vitamins, allergy extracts, serums and vaccines prescribed by a physician for preventing or treating an illness. Preventive vaccines are limited to a payable amount of $100 per benefit year per insured person.
- Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to a payable amount of $20 per visit per insured person.
- Anaesthetic administered during surgery outside a hospital, to a maximum of $50 per day for each insured person.
- Reagent strips and syringes for the treatment of diabetes.
- Smoking-cessation products or drugs that appear on the formulary of the Régie de l'assurance-maladie du Québec (RAMQ), in excess of the amount covered by the RAMQ, to a maximum of $600.

This plan covers these different types of drugs at different levels. It all depends on where the drug fits into the following table. This table applies to all eligible employees and pensioners, whether or not they reside in Québec.

Is the drug you are purchasing on the formulary of the Régie de l'assurance-maladie du Québec (RAMQ)?

Yes	No
In this case, the drug is covered, after the deductible, at 80% (or 100% once the combined expenses for RAMQ and Non-RAMQ drugs reach $3,000).	In this case, the drug is covered at 60% throughout the year, after the deductible. (or 100% once the combined expenses for RAMQ and Non-RAMQ drugs reach $3,000)

Please note:

- All covered drugs must legally require that a prescription be issued.
- The medical experts at RAMQ determine which drugs are "appropriate" for coverage under its formulary. These experts also determine whether, and to what extent, new drug therapies should be covered. Should you have any questions about this, please contact the RAMQ directly.
- The plan automatically covers new drugs approved for use by Health Canada and the corresponding provincial health agencies, unless specifically excluded by Concordia or Sun Life Financial.

RAMQ Drug Plan

If you live in Québec, once you reach age 65, you automatically become covered under the drug plan of the Régie de l'assurance-maladie du Québec (RAMQ).

By law, you have the choice to remain covered under the RAMQ drug plan or to receive equivalent RAMQ drug coverage under the Concordia Health Plan.

When you are covered under the RAMQ drug plan:

- you and your insured eligible dependents remain in the Concordia Health Plan for coverage relating to non-RAMQ drugs and other eligible expenses;
- your dependents must be covered by the RAMQ plan for RAMQ drugs;
- the RAMQ plan is the primary payer for RAMQ drugs; and
- you can submit a claim to the Concordia Health Plan for amounts not reimbursed by the RAMQ plan. In fact, when you use the direct-payment drug card, the plan covers the difference between your coverage under the RAMQ plan and what the Concordia Health Plan would have paid had you not been participating in the RAMQ plan. As a result, your reimbursement from both plans combined is equal to what employees and pensioners under age 65 would get under the Concordia Health Plan.

To date, all individuals eligible for the RAMQ drug plan participate in it because of its cost effectiveness.

Benefits Services will assume that you will remain covered under the RAMQ drug plan, unless:

- you provide instructions to the contrary; and
- you pay the additional, required premiums

Emergency care and travel assistance outside your province of residence (reimbursed at 100%, with no deductible)

Your travel benefit gives you access to the expertise of Global Excel Management (GEM), our emergency travel assistance provider. In the case of a medical emergency while you are travelling out of your home province, this service can help you and your family 24 hours a day, 7 days a week.

To be insured for this benefit, you and your eligible dependents must have provincial health care coverage. Expenses for hospital, medical and paramedical services as well as travel assistance benefits are eligible if they are:

- incurred as a result of an accident or illness that occurs while travelling outside your province of residence during the first 180 days of a trip;
- included in the list of eligible expenses under the plan; and
- not payable by a government body or under another private insurance plan.

The overall lifetime maximum reimbursement of eligible expenses for emergency care and travel assistance outside your province is $3,000,000 per insured person.

All payments will be made in Canadian dollars.

Non-emergency care

The plan does not cover any expenses incurred by you or your insured dependents on a non-emergency or referral basis, while outside your province of residence.

Other special exclusions and limitations also apply

In the event of a medical emergency contact Global Excel Management (GEM) immediately:

If you are calling from...	Dial...
Canada and United States	1- 800-511-4610
From anywhere else	1-519-514-0351 (collect call)
Fax	1-519-514-0374

Hospital care (reimbursed at 100%, with no deductible)

- **Semiprivate room**
  The cost for a semiprivate room in:
  - a public general hospital that exceeds the amount covered by the provincial health plan (or the same amount toward the cost of a private room), plus any user fees the hospital may charge, where permitted by law; or
  - a licensed convalescent hospital. The maximum stay is 60 days for all admissions per benefit year. The insured person must be admitted within 14 days after being discharged from a hospital where he or she was an inpatient.
- **Standard ward**
  In case of hospitalization in Canada, the portion of standard ward accommodation that is not covered by your provincial medical plan, if any.

Coverage is provided for acute care, for an unlimited stay.

Medical and paramedical care

- **Ambulance services**, by ground in the event of a medical emergency, or if the insured person must be transferred to another hospital, including transportation from the place of the accident or illness to the nearest hospital where adequate treatment is available, between hospitals, and from the hospital to the place of residence of the insured person when the condition warrants it. Transportation by air ambulance to the nearest hospital where adequate treatment is available, or to another hospital when certified as medically necessary by the attending physician, is also covered.

- **Artificial** limbs or eyes, plaster of Paris or fiberglass casts, trusses, braces, walkers or crutches

- **Dental treatment directly resulting from an accidental blow to the mouth,** causing damage to healthy natural teeth, provided the treatment is rendered within 6 months following the accident and that coverage is still in force.
  If the claim is incurred by a dependent child who is age 18 or under, the 6-month period may be extended, upon the written recommendation of the attending licensed physician, when additional time is required to allow for the accidental injury to heal properly. Reimbursement for such dental treatment is limited to the least expensive procedure that will provide a professionally adequate result.

- **Diagnostic services**, such as lab tests, X-rays, or similar imaging procedures, subject to a maximum reimbursement of $1,000 per benefit year. New diagnostic technologies will be covered only when they are not considered “experimental.” A maximum reimbursement for diagnostic testing helps keep the level of premiums in check. It also gives plan members some element of control over the cost of emerging - and usually more expensive - diagnostic technologies, such as MRIs. These services are normally available, without charge, in hospitals.

When a person chooses to obtain these services in a private clinic — for which the Concordia Health Plan covers the cost — it affects the plan premiums for every member.

- **Elastic support stockings,** for a maximum reimbursement of three pairs each benefit year.

- **Hearing aids**, (excluding batteries) prescribed by a licensed otolaryngologist, for a maximum reimbursement of $400 for each covered individual in any consecutive 60-month period.

- **Orthopedic shoes and in-depth shoes,** (including adjustments required thereto but excluding off-the-shelf shoes that are regular stock) that are prescribed by a podiatrist or a licensed physician, for a maximum of 2 pairs each benefit year. Orthopedic shoes are custom-molded shoes specifically designed to correct a foot defect.

- **Orthotics**, when prescribed by a podiatrist or a licensed physician up to one pair and a maximum reimbursement of $250 per benefit year. Orthotics are considered eligible when they are not solely for athletic use.

- **Paramedical practitioners**, provided they are **duly qualified, operating within their recognized field and are members, in good standing, of their professional association:**
    - **Physiotherapists, massage therapists, naturopaths, acupuncturists, occupational therapists, athletic therapists, physical rehabilitation, kinesiologists/kinotherapists, Chiropractors, osteopaths, podiatrists, chiropodists, podologists,** are covered at **80%** of reasonable and customary charges per treatment, subject to a maximum reimbursement of $1,000 combined for all practitioners for each covered individual per benefit year.

    - The plan also covers:
        - $100 for the surgical removal of toenails or the excision of plantar warts by a qualified podiatrist. This amount is not included in the above maximum.
        - Imaging techniques by a chiropractor or an osteopath, for a maximum reimbursement of $25 per benefit year. This amount is not included in the $1,000 maximum for diagnostic services.

    - **Audiologists and speech therapists,** for a combined maximum reimbursement of $1,000 for each covered individual per benefit year.
    - Where duplicate coverage is provided for **paramedical practitioners** under a provincial health plan, the Concordia Health Plan pays the difference, if any between:
        - your coverage under the provincial plan; and
        - what the Concordia Health Plan would otherwise have paid

    Where duplicate coverage is provided for **paramedical practitioners** under a provincial health plan, the Concordia Health Plan pays the difference, if any between:

        - your coverage under the provincial plan; and
        - what the Concordia Health Plan would otherwise have paid

- **Registered graduate nurse,** for services prescribed by a licensed physician, while the patient is not confined to a hospital. If a registered nurse is not available, medically required nursing services of a registered nursing assistant or a licensed practical nurse are covered. However, any such nurse must not ordinarily reside in your home or be a close relative. Also, services must not be rendered solely for custodial care, supervision or companionship. There is a maximum reimbursement of $25,000 per covered individual per benefit year.

- **Therapeutic equipment and medical supplies** that are medically required and intended to cure or treat an affliction including the following:
    - Purchase of glucometer or reflectant meter, to a maximum of $150 and one device for any consecutive five-year period;
    - Purchase or rental of oxygen and equipment required for its administration, at the discretion of Sun Life Financial;
    - Apnea monitor;
    - TENS nerve stimulators;
    - Colostomy, ileostomy or uretherostomy supplies;
    - Purchase of one external breast prosthesis per person in each 24 consecutive months, when required because of total or radical mastectomy, including the purchase of two surgical brassieres;
    - Purchase of one wig per lifetime when required as a result of chemotherapy;
    - Other therapeutic equipment, including, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines; and

  Other routinely covered medical supplies.
- **Wheelchair or hospital bed,** either rented or, at the insurance company's option, purchased. The plan covers one wheelchair per insured person in a lifetime; repairs and batteries are not covered.

Psychologists, psychiatrists and psychotherapists (reimbursed at 80%)

- **Services of psychologists, psychiatrists and psychotherapists, who are operating in their recognized field and are members, in good standing, of their professional association,** for the clinical treatment of mental and nervous disorders, provided such treatment is rendered while the patient is not confined to the hospital.
  The maximum reimbursement is $1,500 per person per benefit year for the services of both psychologists, psychiatrists and psychotherapists combined, for each covered individual per benefit year.

Vision care for eligible employee groups (reimbursed at 80%)

- **Eye surgery**, to correct myopia, hypermetropia and astigmatism.
- **Glasses (lenses and frames) and contact lenses, including their replacement and repairs** provided they are prescribed in writing by a qualified opthamologist or a licensed optometrist and dispensed by a qualified opthamologist, a licensed optometrist or a qualified optician. The plan does not cover non-prescription glasses, safety glasses, or glasses for cosmetic or esthetic purposes. It also does not cover sunglasses unless they have the same prescription as your regular glasses.
- **Eye examinations, including eye refraction**, performed by a qualified ophthalmologist or a licensed optometrist.

The maximum reimbursement for all eligible vision care expenses is $160 per person per 24-month period (12-month period for children under age 18).

The provincial health plan will cover eye exams for those under age 18 and those age 65 and over.

Exclusions & limitations

The following provisions apply for the plans you are eligible to participate in if you are a full-time employee, part-time faculty or a continuing education instructor. However, if you are a part-time employee covered under the RAMQ Drug Plan Equivalent, you are covered for the drugs listed on the RAMQ formulary; for more details, go to the government plan site.

The Concordia Health Plan does not cover:

- Any charges in excess of the usual and prevailing charges for the area in which the service was rendered.
- Any one prescription for drugs or medicines in excess of a 60-day supply or a 100-day supply in the case of maintenance drugs
- Any services, treatment or supplies that an insured person receives without charge, or that are reimbursed under a provincial or federal law. If that person is not covered under these laws, Sun Life Financial will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the person's province of residence.
- Charges by a licensed physician for time spent travelling, broken appointments, transportation costs, room rental expenses, or for advice given by telephone or any other means of telecommunication.
- Charges for drugs prescribed for the treatment of infertility that exceed a lifetime maximum of $5,000.
- For an insured person, whether or not domiciled in Quebec, products or drugs used as smoking cessation aids that are covered under the Quebec drug insurance plan, in accordance with the provisions provided for under the Quebec Drug Insurance Plan.
- Cosmetic surgery or treatment, unless required for the correction of damage caused by accidental injury and begun within 90 days following the accident sustained while you or your insured dependent is covered under the plan.
- Custodial care.

- Dental services or supplies and appliances, except as described under Dental treatment directly resulting from an accidental injury to natural teeth.
- Diapers for incontinence.
- Diaphragms, condoms, contraceptive jellies or appliances normally used for contraception whether or not prescribed for a medical reason.
- Drugs available without a prescription, whether or not they are prescribed for a medical reason, except drugs that must be covered by law in Québec.
- Drugs, sera, injectables and supplies that are not approved by Health Canada or that are experimental or limited in use, whether or not so approved.
- Equipment such as "Obus Form" type.
- Exercise and fitness programs; floating, mud and therapeutic baths; postural evaluations; and ear candling.
- Expenses incurred as a result of self-inflicted injuries, while sane or insane.
- Expenses incurred for bodily injury resulting directly or indirectly from insurrection, war, and participation in a riot or service in the armed forces of any country.
- Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or by the appropriate medical specialty society.
- Monitoring devices such as stethoscopes, sphygmomanoters and similar equipment, and domestic appliances such as air purifiers, air conditioners, whirlpools, and similar equipment.
- Non-emergency care while outside your province of residence: The plan does not cover any expenses incurred by you or your insured dependents on a non-emergency or referral basis, while outside your province of residence.
- Periodic health checkups or examinations required for the use of a third party.
- Prescriptions dispensed by a doctor, dentist, clinic or in any non-accredited hospital pharmacy.
- Products, hormones and injections used in the treatment of obesity. Xenical is a covered drug if the insured person's body mass is equal to or greater than 30, or equal to or greater than 27 if this person presents other risk factors.
- Products used in the treatment of sexual dysfunctions.
- Vision care examinations, unless you are part of an eligible employee group.
- Sclerosing injections used in the treatment of varicosities, telangiectasia and minor dilation when this treatment is primarily for cosmetic purposes.
- Services or an acupuncturist for habit-breaking treatment (e.g., nail biting, smoking) or treatment of obesity.
- Services or supplies for which the individual receiving them is not required to make payment, or where payment is received as a result of legal action or settlement.
- Services or supplies obtained in connection with an injury sustained while committing or attempting to commit a criminal offence.
- Services or supplies to the extent that such services or benefits for such services are available under any plan or program established pursuant to the laws or regulations of any government, including Workers' Compensation, any motor vehicle no-fault coverage required by statute, and any services to the extent that any government prohibits the payment of insurance benefits therefor.
- Services rendered and received before coverage for you or your eligible dependent became effective.
- Services, treatment or supplies provided to the insured person by the employer.
- Supplies and services of a preventive nature (other than vaccines).
- The following products, whether prescribed or not: shampoos and other scalp care products, including hair growth products; beauty care products; cosmetics; so-called "natural" products and homeopathic preparations; sunscreens; soaps; over-the-counter laxatives; over-the-counter antacids; skin softeners; disinfectants and ordinary dressings; mineral water; any infant milk formulas; protein

and food supplements; any other proprietary medicines which bear a general product number, as defined by the Foods and Drugs Act.
- Travel for health reasons.
- For an insured person age 65 and over domiciled outside of Quebec, expenses used to cover the Ontario Drug Benefit Plan or other Provincial Drug Benefit Plan deductible and co-insurance amount for individuals insured under this public plan.
- For expenses used to cover the Quebec drug insurance plan deductible and co-insurance amount for individuals insured under this public plan.
- Vitamins (other than those that can only be injected and which are not for weight loss) and dietary supplements.
- Wheelchairs adapted or designed for sports activities.

Special exclusions and limitations for emergency care and travel assistance outside your province of residence

No benefit is payable for:

- expenses incurred under any of the conditions listed as an exclusion in the list above;
- expenses not included in the list of eligible expenses;
- expenses for services, treatment, or supplies received free-of-charge or normally reimbursed under provincial or federal law;
- expenses incurred after returning or refusing to return upon request, to the province of residence;
- expenses incurred on a non-emergency or referral basis;

If you or your insured eligible dependent fails to immediately contact Global Excel Management when emergency medical services are required, reimbursement of eligible expenses may be reduced or denied.

Neither Concordia, Global Excel Management nor Sun Life Financial is responsible for the availability or quality of medical treatment or services received by you or an insured eligible dependent.

Claims

How to file a claim

The claim procedures vary according to the type of expense, as follows:

- Drugs
- All eligible expenses other than drugs

Concordia provides a practical and convenient drug card handled by Sun Life Financial.

Drugs

The card offers lots of advantages.

- There are no forms to complete.
- You know right away your portion of the drug's cost and the plan's portion of costs, too.
- The Travel card includes the telephone numbers of Allianz Global Assistance, which provides assistance 24 hours a day, seven days a week, in the event of medical emergencies while travelling outside your province of residence.

Want to know more?

What the card covers

The drug card applies for a wide range of prescription drugs, including those appearing on the formulary of the Régie de l'assurance maladie du Québec (RAMQ).

How the card works:

1) Give your card with your prescription to any participating pharmacist in Canada.
2) If your pharmacist asks you, your card is labelled a "direct-payment" drug card.
3) Within seconds, this data is electronically processed.
4) You pay the total cost of your share of the claim to the pharmacist. He or she will give you a receipt showing your portion of the cost you have to pay, i.e., the deductible and coinsurance
5) Sun Life Financial will automatically pay the other portion of your claim. You have no claim form to complete

Get directly involved in managing the cost of the plan. By asking your doctor about less expensive therapeutic options or your pharmacist about generic options that cost less than brand-name drugs, you- and the plan - save money. This, in turn, helps keep your premium rates lower.

Who can use the card

All participants can use the card.

Their eligible dependents can also use the drug card, provided you complete the Registration of Eligible Dependents form and return it to Benefits Services. All health insurance claims are handled based on the information provided on this form. **Claims for dependents who are not properly registered will not be paid.**

You must advise Benefits Services promptly of any changes to your covered dependents. No claims will be paid for any dependent that has not been properly registered under the plan.

When the card will not work and you must then submit a claim form to Sun Life Financial

The drug card will not work if:

- you are buying drugs that are not on the RAMQ formulary;
- your pharmacist is not a member of the TELUS network;
- you are outside Canada;
- you are claiming eligible expenses other than drugs; or
- your spouse and dependent children are covered elsewhere.

Your travel card

Your travel benefit gives you access to the expertise of Global Excel Management (GEM), our emergency travel assistance provider. In the case of a medical emergency while you are travelling out of your home province, this service can help you and your family 24 hours a day, 7 days a week. Additional services can include support such as hotel accommodation and meals and replacement transportation tickets, if your return trip is delayed because of a medical emergency. See details and conditions on www.mysunlife.ca (select Print travel card then click Read more).

Write your personal information on the front of this card as Global Excel Management will need this information in an emergency. Put this card with your other travel documents, for easy access to toll-free phone numbers, worldwide.

Note that in case of emergency you or someone with you must call the Global Excel Management operations center before receiving medical care. Global Excel Management must pre-authorize any invasive or investigative procedures (e.g., surgery, angiogram, MRI), except in extreme circumstances. If you don't contact Global Excel Management your claim could be reduced or declined

If you have questions about the card, coverage or your claims

Call Sun Life Financial at: 1-800-361-6212

All expenses other than drugs

Hospital expenses

1. Ask the hospital to send the bill for all expenses not covered by your provincial health plan to Sun Life Financial, or you can submit the claim yourself.
2. Sun Life Financial will reimburse the hospital for all eligible expenses, according to the applicable percentage of reimbursement.
3. You must pay the hospital directly for all expenses not eligible for reimbursement.

Other eligible expenses

1. For all eligible expenses not submitted electronically, keep all receipts for the medical expenses of each covered individual.
2. Once the accumulated expenses exceed the deductible, complete a Sun Life Financial claim form.
3. Complete the form, attach the original receipts, and send everything to Sun Life Financial, at the following address:

   Sun Life Assurance Company of Canada
   P.O. Box 11658 Stn CV Montreal, QC H3C 6C1

Eligible expenses for you and your dependents will be reimbursed directly to you.

When to file a claim

Claims must be submitted within four months following the benefit year in which the eligible expenses were incurred.

If your insurance ends for any reason, all claims must be submitted within 90 days of the date your coverage ends.

In the event of an accident, you must send written notice to Sun Life Financial within 30 days after the accident.

No action or proceedings may be initiated against Sun Life Financial for the recovery of any claim within 60 days or after three years following the expiration of the time in which proof of claim is required.

Submitting a claim

Changes in personal data

To make sure the insurer has the right information on file and can continue covering you and your

dependents, please keep Benefits Services informed of any changes in personal data on you and your family.

Making benefit changes after a life event

When an eligible life event occurs, you can modify your benefit choices within 31 days following the event.

Eligible life events include a new spouse, having a baby, divorce or legal separation, and the loss of your spouse's coverage where he or she works. Please be aware that changes presented within 31 days of the event will become effective on the exact date of the event. Evidence of insurability may be requested when changes are presented more than 31 days after the event.

What to do if your child is a full-time student age 21 or over

If you wish to cover any dependent children who are full-time students age 21 or over and who depend on you for support, you must complete the section on Dependent Information on the *enrolment form.*

This confirmation of full-time school attendance is required once a year and is valid for a full school year from September until August 31 of the following year.

If proof of full-time school attendance is provided for any session other than the fall session starting in September, that proof will be valid only until the end of the benefit year; new proof of full-time school attendance will be required again in the following year.

If you want...

More information, contact:
Tel.: 1-800-361-6212

If you have coverage elsewhere

If you have a spouse and your spouse also has a health plan:

- certain expenses not covered by your spouse's plan may be fully or partially covered by the Concordia Health Plan;
- you may be entitled to a full or partial reimbursement from your spouse's plan for your own expenses that are not covered under the Concordia plan; and
- the drug card will work for your spouse provided he or she has a drug card (from his or her plan) that is also part of the TELUS network. You must, however, show both cards to the pharmacist; and

- your dependent children are covered under both your plan and your spouse's plan but your spouse does not have a drug card that is part of the TELUS network, the drug card under the Concordia plan will work for your dependent children provided your birthday is before your spouse's birthday, in the benefit year.

Note: Your drug card will work for your spouse if he or she also works at Concordia and you both have family coverage. In this case, you must show both cards to the pharmacist.

Where there is duplicate coverage, payment is coordinated as follows. In any event, the combined benefits from the two plans may not exceed the expenses actually incurred.

- Eligible expenses that **you** incur are reimbursed first by the Concordia Health Plan, followed by your spouse's plan, if a balance remains.
- Eligible expenses that your **spouse** incurs are reimbursed first by your spouse's plan, and then by the Concordia Health Plan, if a balance remains.
- Eligible expenses that your covered **dependent children** incur are first reimbursed by the plan of the parent whose birthday falls earlier in the benefit year. Any balance remaining should then be submitted to the other spouse's plan for payment.

If the eligible expenses were incurred by...	**Submit your claims to the various plans in the following order for reimbursement:**
You	1. Concordia Health Plan 2. Your spouse's plan, if a balance remains
Your spouse	1. Your spouse's plan 2. Concordia Health Plan, if a balance remains
Your dependent children	1. The plan of the parent whose birthday falls earlier in the year 2. The plan of the other parent, if a balance remains. If your marital relationship has ended and you have dependent children from this relationship: 1. The plan of the parent with custody of the child 2. The plan of the spouse of the parent with custody of the child. 3. The plan of the parent not having custody of the child. 4. The plan of the spouse of the parent not having custody of the child. If priority cannot be established this way, benefits will be prorated between or among the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

Please note:

- **If you are an active part-time employee under more than one plan**
  In this case, priority will be given to the plan for which you work the highest number of hours per week.
- **If your spouse's plan does not coordinate the payment of benefits with other plans**
  In this case, your spouse's plan is the first payer and the Concordia Health Plan the second payer.
- **If another plan pays benefits that the Concordia Health Plan should have paid**
  In this case, Sun Life Financial has the right, exercisable alone and in its sole discretion, to pay to the other party that paid those benefits in the first place any amount that it sees fit to satisfy the intent of this coordination of benefits provision.
  Such amounts will be deemed to be benefits paid under the Concordia Health Plan. Also, to the extent of such payments, Sun Life Financial will be fully discharged from liability under the Concordia Health Plan.
- **Insurer's right to receive and release information on insured persons**
  Sun Life Financial may, with proper authorization, release to or obtain from any party any information, with respect to any insured person, that Sun Life Financial deems necessary to coordinate benefits. Any individual claiming benefits under this policy must provide Sun Life Financial with the necessary information.
- **Insurer's right to recover excess benefit payments**
  If Sun Life Financial has exceeded the maximum payment needed to satisfy the intent of the coordination of benefits provision, it has the right to recover such excess payment from any individuals to or for whom such payments were made, from any other insurance company or from any other organization.

Life events

Certain events in life can affect your benefits. Choose an event below to learn more. What if...

My dependent child reaches age 21

- Your dependent child's coverage will end unless he or she is:
  - a full-time student, dependent on you for support; or
  - mentally or physically handicapped, and incapable of self-sustaining employment, as well as wholly dependent on you for support.
- You must provide the insurance company with satisfactory proof of your child's continued eligibility no later than 31 days after he or she turns 21. Proof may also be periodically required thereafter.
- Remember: your child must be unmarried and living in Canada.

I have a change to my marital status

Health Plan

- Your spouse's coverage will end, unless you are separated for a period of less than 90 days.
- If you have dependent children and your spouse becomes covered under Concordia's plan and another plan, eligible expenses that your covered dependent children incur will first be reimbursed by the plan of the parent whose birthday falls earlier in the benefit year. Any balance remaining should then be submitted to the other spouse's plan for payment.

I die while receiving pension payments

Health Plan

- Your insured eligible dependents may continue to be covered under the plan until they no longer meet the definition of eligible dependents or until death, provided they pay the premiums.

When coverage ends

For you

Your coverage under the Concordia Health Plan will end on the earliest of:

- The date you are no longer part of an eligible employee group that participates in the Concordia Health Plan;
- the date your employment ceases before you are eligible to retire;
- the date you cease to be actively at work;
- the end of a plan period;
- the date your eligible employee group ceases to participate in the Concordia Health Plan;
- the date you stop paying the required premiums;
- the date you join the armed forces on a full-time basis;
- the date the contract is cancelled; and
- the date of your death

For your eligible dependents

Your eligible dependents' coverage ends on the earliest of:

- the date your coverage ceases (unless they make arrangements to maintain their coverage following your death);
- the date they no longer qualify as eligible dependents; and
- the date you cancel their coverage because duplicate coverage is provided through your spouse's plan.

Policy number: 103424

General Inquiries:
Concordia University: 514-848-2424 Ext 3394 | hr-employeeservices@concordia.ca
Sun Life Financial: 1800-361-6212 | www.mysunlife.ca