ALUMO

FANSHAWE STUDENT UNION
www.fsu.ca

2026-2027

Domestic Student Health Plan

Full-time Students Only

Policy # 100011701
Group # 514560

Designed for the students of Fanshawe College

As a full-time post secondary domestic student you are automatically covered for the benefits outlined in this brochure and online at **fsu.ca/health**

Visit the FSU Office (SC-1000) for questions or concerns

ALUMO

Questions? Call Alumo: 519-913-3701

Please have your student ID readily available.

2255 Sheppard East, Atria 1, 2nd Floor Suite 202 Toronto, ON M2J 4Y1

www.alumo.ca

This booklet has been prepared as a brief outline of the benefits available to you under your Group Insurance Plan. It is not an insurance policy, but an informal explanation of benefits provided by the plan.

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SECTION I - BALANCED PLAN

Drug Coverage

If an Insured requires drugs or medicines and such drugs or medicines are prescribed by a physician, and purchased by the Insured for use during the term of the policy, subject to a dispensing maximum of a 90-day supply, the Company will reimburse 90% of the reasonable and customary charges incurred, to a maximum of $5,000.00 per Insured, per policy year, for expenses for:

a) most prescription drugs or medicines;
b) insulin injectables;
c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of $1500.00 per Insured per policy year (pseudo din # 910333 must be used for all diabetic supplies);
d) allergy serums;
e) preventative vaccines (excluding Hepatitus B);
f) Accutane;
g) oral, injectable and the patch (contraceptives);
h) IUD's, subject to a maximum of $200.00 per Insured per policy year;
i) the Nuva Ring (contraceptive), subject to a maximum of $178.00 per Insured, per policy year.

Please visit our website www.alumo.ca for more details on our prescription plan partners.

Reimbursement will be made for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.

The maximum amount allowed for a dispensing fee is $10.50; any amount charged over and above will be payable by the student.

EXCLUSIONS

a) over-the-counter products, or medicines available without a prescription;
b) fertility drugs; erectile dysfunction drugs; male pattern baldness remedies;
c) anti-smoking remedies (nicorette gum, patches or similar products);
d) oral vitamins; injectable vitamins that are non-prescription;
e) drugs, hormones, products and injections for the treatment of obesity;
f) infant formula, dietary foods and aids; salt and sugar substitutes;
g) first-aid and surgical supplies; atomizers, vaporizers;
h) drugs which are experimental in nature; diagnostic aids and laboratory tests;
i) Hepatitis B vaccine;
j) sclerosing agents; all acne preparations excluding Accutane.

SECTION I - BALANCED PLAN

Dental Coverage

MAXIMUM COVERAGE
During each policy year, the maximum coverage per Insured is $600.00. Reimbursement is considered according to the Ontario Dental Association's Suggested Fee Guide for General Practitioners.

*Additional discounts are available through the Dental Network. Please visit www.alumo.ca for more information.

BASIC AND PREVENTIVE SERVICES
100% of one examination and consultation, including any necessary x-rays and diagnostic services at time of exam, during each policy year.

ELIGIBLE EXAMS

a) complete oral examinations
b) recall oral examinations
c) emergency or specific oral examinations
d) consultation

ELIGIBLE X-RAYS

a) full mouth series, maximum of 16 films in any 36 consecutive months
b) panorex (one in any 36 consecutive months)
c) periapical (no more than 16 films in any 36 consecutive months)
d) bitewing (no more than 4 films in 12 consecutive months)
e) occlusal (no more than 4 films in 12 consecutive months)

100% of one cleaning and one unit of polishing; includes up to 4 units of scaling (above the gum line).
Fluoride treatments will be limited to one per policy year.

MINOR RESTORATIVE SERVICES
85% of the cost of amalgam, silicate, composite or tooth- coloured fillings and space maintainers.

Please note the following information:

- space maintainers only applicable to dependents under 15 years of age
- tooth-coloured fillings are covered provided no more than 24 consecutive months have elapsed since the last restoration
- multiple restorations on a common surface placed on the same service date will be considered a single restoration
- maximum benefit payable will not exceed the fee for a 5 surface restoration regarding the same tooth during one sitting

EXTRACTIONS AND ORAL SURGERY

85% coverage of extractions and residual root removal, up to four wisdom teeth in any policy year, other oral surgery is covered at 10% as noted below.

THE SERVICES LISTED BELOW ARE COVERED AT 10%

Endodontics - will include, where applicable, treatment plan, local anaesthesia, tooth isolation, clinical procedures, sutures, appropriate radiographs (x-rays) and follow-up care:

a) pulpotomy (not in conjunction with restoration of root canal therapy if rendered within 30 days)
b) root canal therapy
c) apexification
d) periapical services
e) root amputation
f) hemisection
g) intentional removal, apical filling and reimplantation

Periodontics

a) non-surgical procedures
b) definitive surgical procedures
c) adjunctive surgical procedures
d) occlusal equilibration
e) periodontal appliances including impression and insertion (no more than one appliance per arch in any period of 24 consecutive months)
f) periodontal appliance repair, maintenance and adjustment (no more than four units in any policy year)

Major Restorative (crowns/bridges/dentures)

Most of the services listed below will be replaced only if the existing appliance is at least 5 years old, if the appliance is temporary and being replaced with a permanent appliance within 12 months of the installation of the temporary appliance or if the appliance was necessary due to the extraction of one natural tooth.

a) Crowns (only if more than 5 years have elapsed since the last placement) will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparations, pulp protection, impressions, temporary coverage, insertion, occlusal adjustments and cementation.
b) Removable prosthodontics will include, where applicable, treatment plan, impressions, jaw relation records, try-in, insertion, occlusal equilibration and 3 months post-insertion care on complete dentures, transitional dentures, acrylic dentures and cast partial dentures.

c) Fixed prosthodontics will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, splinting, intraoral indexing for soldering purposes, insertion, occlusal adjustments and cementation on pontic, retainers and abutments.

EXCLUSIONS

a) services not included in the list of defined eligible services (e.g. temporary fillings);
b) completion of claim forms, advice by phone, or charges for missed or cancelled appointments;
c) cosmetic surgery or treatment when classified as such by the Company;
d) any dental treatment not yet approved by the Canadian Dental Association or which is clearly experimental in nature;

This is a summary of the benefits available under the Group Insurance Plan. Further details may be obtained from the plan provider.

SECTION I - BALANCED PLAN

Extended Health Coverage

This benefit helps pay the cost of eligible medical expenses incurred by an Insured and their insured family members. An Insured will be reimbursed for eligible expenses not covered by the Provincial Medicare Plan, subject to the deductible, if any, and percentage reimbursed shown below. Payment will be made for those eligible expenses which are a) reasonable and medically necessary and b) incurred on the prior recommendation of a legally qualified physician except where otherwise indicated.

ELIGIBLE EXPENSES (IN PROVINCE)

ClaimSecure will pay 100% of Vision Care eligible expenses and 80% of all other eligible expenses unless otherwise indicated. The following are the eligible expenses provided in the province the expense is incurred in.

AMBULANCE

a) A licensed ground ambulance when used to transport an Insured because of emergency or in-patient treatment i) from the place where the Insured suffers the sickness to the nearest hospital where adequate medical treatment is available, ii) from one hospital to another, or iii) from a hospital to the Insured's residence, when an Insured's condition warrants it.
b) Emergency transportation by a licensed air ambulance to the nearest hospital where adequate treatment is available or to another hospital when certified as essential by the attending physician. If medically necessary, in flight services of a registered nurse or necessary medical personnel and the return air fare for the registered nurse or necessary medical personnel will be included.

PARAMEDICAL PRACTITIONERS

$30.00 per treatment to a maximum of $400.00 each policy year for each type of practitioner listed below:

a) Combined services of a clinical psychologist or speech therapist;
b) Combined services of a naturopath or a chiropractor;
c) Services of a registered massage therapist, if recommended by a physician;

$50.00 per treatment to a maximum of $450.00 each policy year for each type of practitioner listed below:

a) Services of a physiotherapist.

ORTHOPEDIC SUPPLIES

Charges for molded arch supports, orthopedic supplies and custom made orthopedic shoes are covered at 80% to a maximum of $200.00, if recommended by a physician, podiatrist or chiropodist;

- Orthopedic supplies as noted above must be dispensed by one of the following providers: orthotist, pedorthist, podiatrist or chiropodist.
- Orthopedic supplies must be dispensed by a different provider than the prescriber.
- Orthopedic supplies prescribed or dispensed by a chiropractor are not eligible.

*When submitting your claim be sure to include the following: Your major medical expense claim form, referral pre-dating treatment, original paid in full invoice, gait analysis or biomechanical exam, a description of the raw materials used in the construction of the orthotic.

PROSTHETIC APPLIANCES

a) Charges for artificial limbs when the loss of the limb occurs while the individual is insured under this benefit, the cost of repair is also eligible; replacement is included when required due to physiological change, but excluding myoelectric appliances;
b) Charges for artificial eyes including reimbursement for one polishing or one remaking of the artificial eye each policy year;
c) Charges for crutches, casts, splints, trusses and braces (does not include dental braces, or expense of a brace or similar device used for non therapeutic purposes or used solely for the purpose of participation in sports or other leisure activities, braces must have rigid or semi rigid materials in them), including replacements when medically necessary;
d) Purchase of an external breast prosthesis when required because of a total or radical mastectomy that has been performed while the individual is insured under this benefit, including the purchase of 2 surgical brassieres, to a maximum of $200.00 per individual each policy year.

MEDICAL SUPPLIES

Charges for compound serums, colostomy supplies, injectible drugs and varicose vein injections, if medically necessary. Such drugs or supplies must be either administered by a physician or dentist or prescribed by a physician or dentist and dispensed by a pharmacist. However, any charges for their administration will not be included.

EQUIPMENT RENTAL

Charges for wheelchairs, walkers, hospital beds, traction kits which are rented for temporary therapeutic use. If, due to extended illness or disability, the need for these items will be long term, the Company, at its sole discretion, may approve the purchase of these items. Repair to a wheelchair will be included up to a lifetime maximum of $250.00.

OTHER ELIGIBLE EXPENSES

a) Charges for oxygen, blood or blood products and the equipment required for its administration;
b) Charges for treatment of a sickness by the use of radiotherapy or coagulotherapy;
c) Charges for laboratory tests done in a commercial laboratory for diagnosis of a sickness but excluding any tests performed in a physician's office or a pharmacy.

VISION CARE

If an Insured incurs expenses for vision care, the Company will pay reasonable and customary charges for:

a) one general optometric examination by an optometrist or ophthalmologist during any 24 consecutive months based on date of first paid claim, to a maximum of $85.00 plus (b) or (c) below;
b) standard eye glass lenses and frames (single vision or bifocal as required) or contact lenses when prescribed by a physician or an optometrist, or replacement of existing eye glass lenses and frames to a maximum of $200.00 in any consecutive 24 months based on date of first paid claim for one complete set of lenses and frames for any one Insured; or
c) contact lenses when prescribed by a physician or optometrist for severe corneal astigmatism, severe corneal scarring, Keratoconus (Conical Cornea) or Aphakia, provided that visual acuity can be improved to at least 20/40 level with contact lenses, but cannot be improved to that level with regular glasses, up to a maximum of $200.00 for one complete set of lenses for any Insured, in any 24 consecutive months based on date of first paid claim. Otherwise, contact lenses are subject to the same maximum as eye glasses and frames.

The Company shall not be liable for any expenses incurred for the provision of sunglasses, safety glasses or any form of eyeglasses provided for cosmetic or aesthetic purposes.

LIMITATIONS AND EXCLUSIONS

a) expenses as a result of any injury or sickness caused by declared or undeclared war or any act thereof;
b) expenses of any kind which would not normally be charged to the Insured provided by the policy were not in effect;
c) expenses incurred from any injury or sickness sustained as a result of employment when the Insured is covered or eligible to receive benefits under the applicable Workplace Safety and Insurance Board's legislation or similar law;
d) expenses as a result of suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
e) cosmetic medical or surgical care, other than due to an accidental bodily injury sustained while the Insured is insured under this benefit;
f) medical treatment which is experimental or investigational in nature;
g) periodic health examinations, broken appointments, physician's costs for traveling or providing telephone advice, third-party examinations, completion of forms or medical reports, travel for health purposes;
h) services, treatment or supplies not included in this benefit;
i) expenses incurred from any injury or sickness as the result of active full-time service in the armed forces of any country;
j) expenses for optical services rendered by a Physician, Licensed, Certified or Registered optician, Licensed, Certified or Registered optometrist or a Licensed, Certified or Registered ophthalmologist employed or engaged by the Fanshawe College;
k) expenses incurred by an Insured who is not covered under any Federal or Provincial Hospital or Medical Plan, or its equivalent.

SECTION II - ENHANCED DENTAL PLAN

Drug Coverage

If an Insured requires drugs or medicines and such drugs or medicines are prescribed by a physician, and purchased by the Insured for use during the term of the policy, subject to a dispensing maximum of a 90-day supply, the Company will reimburse 80% of the reasonable and customary charges incurred, to a maximum of $2,500.00 per Insured, per policy year, for expenses for:

a) most prescription drugs or medicines;
b) insulin injectables;
c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of $1500.00 per Insured per policy year (pseudo din # 910333 must be used for all diabetic supplies);
d) allergy serums;
e) preventative vaccines (excluding Hepatitus B);
f) Accutane;
g) oral, injectable and the patch (contraceptives);
h) IUD's, subject to a maximum of $200.00 per Insured per policy year;
i) the Nuva Ring (contraceptive), subject to a maximum of $178.00 per Insured, per policy year.

Please visit our website www.alumo.ca for more details on our prescription plan partners.

Reimbursement will be made for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.

The maximum amount allowed for a dispensing fee is $10.50; any amount charged over and above will be payable by the student.

EXCLUSIONS

a) over-the-counter products, or medicines available without a prescription;
b) fertility drugs; erectile dysfunction drugs; male pattern baldness remedies;
c) anti-smoking remedies (nicorette gum, patches or similar products);
d) oral vitamins; injectable vitamins that are non-prescription;
e) drugs, hormones, products and injections for the treatment of obesity;
f) infant formula, dietary foods and aids; salt and sugar substitutes;
g) first-aid and surgical supplies; atomizers, vaporizers;
h) drugs which are experimental in nature; diagnostic aids and laboratory tests;
i) Hepatitis B vaccine;
j) sclerosing agents; all acne preparations excluding Accutane.

SECTION II - ENHANCED DENTAL PLAN

Dental Coverage

MAXIMUM COVERAGE
During each policy year, the maximum coverage per Insured is $800.00. Reimbursement is considered according to the Ontario Dental Association's Suggested Fee Guide for General Practitioners.

*Additional discounts are available through the Dental Network.
Please visit www.alumo.ca for more information.

BASIC AND PREVENTIVE SERVICES
100% of one examination and consultation, including any necessary x-rays and diagnostic services at time of exam, during each policy year.

ELIGIBLE EXAMS

a) complete oral examinations
b) recall oral examinations
c) emergency or specific oral examinations
d) consultation

ELIGIBLE X-RAYS

a) full mouth series, maximum of 16 films in any 36 consecutive months
b) panorex (one in any 36 consecutive months)
c) periapical (no more than 16 films in any 36 consecutive months)
d) bitewing (no more than 4 films in 12 consecutive months)
e) occlusal (no more than 4 films in 12 consecutive months)

100% of one cleaning and one unit of polishing; includes up to 4 units of scaling (above the gum line).
Fluoride treatments will be limited to one per policy year.

MINOR RESTORATIVE SERVICES
90% of the cost of amalgam, silicate, composite or tooth-coloured fillings and space maintainers.

Please note the following information:

- space maintainers only applicable to dependents under 15 years of age
- tooth-coloured fillings are covered provided no more than 24 consecutive months have elapsed since the last restoration
- multiple restorations on a common surface placed on the same service date will be considered a single restoration
- maximum benefit payable will not exceed the fee for a 5 surface restoration regarding the same tooth during one sitting

EXTRACTIONS AND ORAL SURGERY

90% coverage of extractions and residual root removal, up to four wisdom teeth in any policy year, other oral surgery is covered at 10% as noted below.

THE SERVICES LISTED BELOW ARE COVERED AT 10%

Endodontics - will include, where applicable, treatment plan, local anaesthesia, tooth isolation, clinical procedures, sutures, appropriate radiographs (x-rays) and follow-up care:

a) pulpotomy (not in conjunction with restoration of root canal therapy if rendered within 30 days)
b) root canal therapy
c) apexification
d) periapical services
e) root amputation
f) hemisection
g) intentional removal, apical filling and reimplantation

Periodontics

a) non-surgical procedures
b) definitive surgical procedures
c) adjunctive surgical procedures
d) occlusal equilibration
e) periodontal appliances including impression and insertion (no more than one appliance per arch in any period of 24 consecutive months)
f) periodontal appliance repair, maintenance and adjustment (no more than four units in any policy year)

Major Restorative (crowns/bridges/dentures)

Most of the services listed below will be replaced only if the existing appliance is at least 5 years old, if the appliance is temporary and being replaced with a permanent appliance within 12 months of the installation of the temporary appliance or if the appliance was necessary due to the extraction of one natural tooth.

a) Crowns (only if more than 5 years have elapsed since the last placement) will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparations, pulp protection, impressions, temporary coverage, insertion, occlusal adjustments and cementation.
b) Removable prosthodontics will include, where applicable, treatment plan, impressions, jaw relation records, try-in, insertion, occlusal equilibration and 3 months post-insertion care on complete dentures, transitional dentures, acrylic dentures and cast partial dentures.

c) Fixed prosthodontics will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, splinting, intraoral indexing for soldering purposes, insertion, occlusal adjustments and cementation on pontic, retainers and abutments.

EXCLUSIONS

a) services not included in the list of defined eligible services (e.g. temporary fillings);
b) completion of claim forms, advice by phone, or charges for missed or cancelled appointments;
c) cosmetic surgery or treatment when classified as such by the Company;
d) any dental treatment not yet approved by the Canadian Dental Association or which is clearly experimental in nature;

This is a summary of the benefits available under the Group Insurance Plan. Further details may be obtained from the plan provider.

SECTION II - ENHANCED DENTAL PLAN

Extended Health Coverage

This benefit helps pay the cost of eligible medical expenses incurred by an Insured and their insured family members. An Insured will be reimbursed for eligible expenses not covered by the Provincial Medicare Plan, subject to the deductible, if any, and percentage reimbursed shown below. Payment will be made for those eligible expenses which are a) reasonable and medically necessary and b) incurred on the prior recommendation of a legally qualified physician except where otherwise indicated.

ELIGIBLE EXPENSES (IN PROVINCE)

ClaimSecure will pay 100% of Vision Care eligible expenses and 80% of all other eligible expenses unless otherwise indicated. The following are the eligible expenses provided in the province the expense is incurred in.

AMBULANCE

a) A licensed ground ambulance when used to transport an Insured because of emergency or in-patient treatment i) from the place where the Insured suffers the sickness to the nearest hospital where adequate medical treatment is available, ii) from one hospital to another, or iii) from a hospital to the Insured's residence, when an Insured's condition warrants it.
b) Emergency transportation by a licensed air ambulance to the nearest hospital where adequate treatment is available or to another hospital when certified as essential by the attending physician. If medically necessary, in flight services of a registered nurse and the return air fare for the registered nurse will be included.

PARAMEDICAL PRACTITIONERS

$20.00 per treatment to a maximum of $300.00 each policy year for each type of practitioner listed below:

a) Combined services of a clinical psychologist or speech therapist;
b) Combined services of a naturopath or a chiropractor;
c) Services of a registered massage therapist, if recommended by a physician;

$40.00 per treatment to a maximum of $350.00 each policy year for each type of practitioner listed below:

a) Services of a physiotherapist.

ORTHOPEDIC SUPPLIES

Charges for molded arch supports, orthopedic supplies and custom made orthopedic shoes are covered at 80% to a maximum of $200.00, if recommended by a physician, podiatrist or chiropodist;

- Orthopedic supplies as noted above must be dispensed by one of the following providers: orthotist, pedorthist, podiatrist or chiropodist.
- Orthopedic supplies must be dispensed by a different provider than the prescriber.
- Orthopedic supplies prescribed or dispensed by a chiropractor are not eligible.

*When submitting your claim be sure to include the following: Your major medical expense claim form, referral pre-dating treatment, original paid in full invoice, gait analysis or biomechanical exam, a description of the raw materials used in the construction of the orthotic.

PROSTHETIC APPLIANCES

a) Charges for artificial limbs when the loss of the limb occurs while the individual is insured under this benefit, the cost of repair is also eligible; replacement is included when required due to physiological change, but excluding myoelectric appliances;
b) Charges for artificial eyes including reimbursement for one polishing or one remaking of the artificial eye each policy year;
c) Charges for crutches, casts, splints, trusses and braces (does not include dental braces, or expense of a brace or similar device used for non therapeutic purposes or used solely for the purpose of participation in sports or other leisure activities, braces must have rigid or semi rigid materials in them), including replacements when medically necessary;
d) Purchase of an external breast prosthesis when required because of a total or radical mastectomy that has been performed while the individual is insured under this benefit, including the purchase of 2 surgical brassieres, to a maximum of $200.00 per individual each policy year.

MEDICAL SUPPLIES

Charges for compound serums, colostomy supplies, injectible drugs and varicose vein injections, if medically necessary. Such drugs or supplies must be either administered by a physician or dentist or prescribed by a physician or dentist and dispensed by a pharmacist. However, any charges for their administration will not be included.

EQUIPMENT RENTAL

Charges for wheelchairs, walkers, hospital beds, traction kits which are rented for temporary therapeutic use. If, due to extended illness or disability, the need for these items will be long term, the Company, at its sole discretion, may approve the purchase of these items. Repair to a wheelchair will be included up to a lifetime maximum of $250.00.

OTHER ELIGIBLE EXPENSES

a) Charges for oxygen, blood or blood products and the equipment required for its administration;
b) Charges for treatment of a sickness by the use of radiotherapy or coagulotherapy;
c) Charges for laboratory tests done in a commercial laboratory for diagnosis of a sickness but excluding any tests performed in a physician's office or a pharmacy.

VISION CARE

If an Insured incurs expenses for vision care, the Company will pay reasonable and customary charges for:

a) one general optometric examination by an optometrist or ophthalmologist during any 24 consecutive months based on date of first paid claim, to a maximum of $85.00 plus (b) or (c) below;
b) standard eye glass lenses and frames (single vision or bifocal as required) or contact lenses when prescribed by a physician or an optometrist, or replacement of existing eye glass lenses and frames to a maximum of $100.00 in any consecutive 24 months based on date of first paid claim for one complete set of lenses and frames for any one Insured; or
c) contact lenses when prescribed by a physician or optometrist for severe corneal astigmatism, severe corneal scarring, Keratoconus (Conical Cornea) or Aphakia, provided that visual acuity can be improved to at least 20/40 level with contact lenses, but cannot be improved to that level with regular glasses, up to a maximum of $200.00 for one complete set of lenses for any Insured, in any 24 consecutive months based on date of first paid claim. Otherwise, contact lenses are subject to the same maximum as eye glasses and frames.

The Company shall not be liable for any expenses incurred for the provision of sunglasses, safety glasses or any form of eyeglasses provided for cosmetic or aesthetic purposes.

LIMITATIONS AND EXCLUSIONS

a) expenses as a result of any injury or sickness caused by declared or undeclared war or any act thereof;
b) expenses of any kind which would not normally be charged to the Insured provided by the policy were not in effect;
c) expenses incurred from any injury or sickness sustained as a result of employment when the Insured is covered or eligible to receive benefits under the applicable Workplace Safety and Insurance Board's legislation or similar law;
d) expenses as a result of suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
e) cosmetic medical or surgical care, other than due to an accidental bodily injury sustained while the Insured is insured under this benefit;
f) medical treatment which is experimental or investigational in nature;
g) periodic health examinations, broken appointments, physician's costs for traveling or providing telephone advice, third-party examinations, completion of forms or medical reports, travel for health purposes;
h) services, treatment or supplies not included in this benefit;
i) expenses incurred from any injury or sickness as the result of active full-time service in the armed forces of any country;
j) expenses for optical services rendered by a Physician, Licensed, Certified or Registered optician, Licensed, Certified or Registered optometrist or a Licensed, Certified or Registered ophthalmologist employed or engaged by the Fanshawe College;
k) expenses incurred by an Insured who is not covered under any Federal or Provincial Hospital or Medical Plan, or its equivalent.

SECTION III - ENHANCED DRUG/EXTENDED HEALTH PLAN

Drug Coverage

If an Insured requires drugs or medicines and such drugs or medicines are prescribed by a physician, and purchased by the Insured for use during the term of the policy, subject to a dispensing maximum of a 90-day supply, the Company will reimburse 100% of the reasonable and customary charges incurred, to a maximum of $5,000.00 per Insured, per policy year, for expenses for:

a) most prescription drugs or medicines;
b) insulin injectables;
c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of $1500.00 per Insured per policy year (pseudo din # 910333 must be used for all diabetic supplies);
d) allergy serums;
e) preventative vaccines (excluding Hepatitus B);
f) Accutane;
g) oral, injectable and the patch (contraceptives);
h) IUD's, subject to a maximum of $200.00 per Insured per policy year;
i) the Nuva Ring (contraceptive), subject to a maximum of $178.00 per Insured, per policy year.

Please visit our website www.alumo.ca for more details on our prescription plan partners.

Reimbursement will be made for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.

The maximum amount allowed for a dispensing fee is $10.50; any amount charged over and above will be payable by the student.

EXCLUSIONS

a) over-the-counter products, or medicines available without a prescription;
b) fertility drugs; erectile dysfunction drugs; male pattern baldness remedies;
c) anti-smoking remedies (nicorette gum, patches or similar products);
d) oral vitamins; injectable vitamins that are non-prescription;
e) drugs, hormones, products and injections for the treatment of obesity;
f) infant formula, dietary foods and aids; salt and sugar substitutes;
g) first-aid and surgical supplies; atomizers, vaporizers;
h) drugs which are experimental in nature; diagnostic aids and laboratory tests;
i) Hepatitis B vaccine;
j) sclerosing agents; all acne preparations excluding Accutane.

SECTION III - ENHANCED DRUG/EXTENDED HEALTH PLAN

Dental Coverage

MAXIMUM COVERAGE
During each policy year, the maximum coverage per Insured is $300.00. Reimbursement is considered according to the Ontario Dental Association's Suggested Fee Guide for General Practitioners.

*Additional discounts are available through the Dental Network.
Please visit www.alumo.ca for more information.

BASIC AND PREVENTIVE SERVICES
70% of one examination and consultation, including any necessary x-rays and diagnostic services at time of exam, during each policy year.

ELIGIBLE EXAMS

a) complete oral examinations
b) recall oral examinations
c) emergency or specific oral examinations
d) consultation

ELIGIBLE X-RAYS

a) full mouth series, maximum of 16 films in any 36 consecutive months
b) panorex (one in any 36 consecutive months)
c) periapical (no more than 16 films in any 36 consecutive months)
d) bitewing (no more than 4 films in 12 consecutive months)
e) occlusal (no more than 4 films in 12 consecutive months)

70% of one cleaning and one unit of polishing; includes up to 4 units of scaling (above the gum line).
Fluoride treatments will be limited to one per policy year.

MINOR RESTORATIVE SERVICES
50% of the cost of amalgam, silicate, composite or tooth- coloured fillings and space maintainers.

Please note the following information:

- space maintainers only applicable to dependents under 15 years of age
- tooth-coloured fillings are covered provided no more than 24 consecutive months have elapsed since the last restoration
- multiple restorations on a common surface placed on the same service date will be considered a single restoration
- maximum benefit payable will not exceed the fee for a 5 surface restoration regarding the same tooth during one sitting

EXTRACTIONS AND ORAL SURGERY

50% coverage of extractions and residual root removal, limited to two wisdom teeth in any policy year, other oral surgery is covered at 10% as noted below.

THE SERVICES LISTED BELOW ARE COVERED AT 10%

Endodontics - will include, where applicable, treatment plan, local anaesthesia, tooth isolation, clinical procedures, sutures, appropriate radiographs (x-rays) and follow-up care:

a) pulpotomy (not in conjunction with restoration of root canal therapy if rendered within 30 days)
b) root canal therapy
c) apexification
d) periapical services
e) root amputation
f) hemisection
g) intentional removal, apical filling and reimplantation

Periodontics

a) non-surgical procedures
b) definitive surgical procedures
c) adjunctive surgical procedures
d) occlusal equilibration
e) periodontal appliances including impression and insertion (no more than one appliance per arch in any period of 24 consecutive months)
f) periodontal appliance repair, maintenance and adjustment (no more than four units in any policy year)

Major Restorative (crowns/bridges/dentures)

Most of the services listed below will be replaced only if the existing appliance is at least 5 years old, if the appliance is temporary and being replaced with a permanent appliance within 12 months of the installation of the temporary appliance or if the appliance was necessary due to the extraction of one natural tooth.

a) Crowns (only if more than 5 years have elapsed since the last placement) will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparations, pulp protection, impressions, temporary coverage, insertion, occlusal adjustments and cementation.
b) Removable prosthodontics will include, where applicable, treatment plan, impressions, jaw relation records, try-in, insertion, occlusal equilibration and 3 months post-insertion care on complete dentures, transitional dentures, acrylic dentures and cast partial dentures.

c) Fixed prosthodontics will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, splinting, intraoral indexing for soldering purposes, insertion, occlusal adjustments and cementation on pontic, retainers and abutments.

EXCLUSIONS

a) services not included in the list of defined eligible services (e.g. temporary fillings);
b) completion of claim forms, advice by phone, or charges for missed or cancelled appointments;
c) cosmetic surgery or treatment when classified as such by the Company;
d) any dental treatment not yet approved by the Canadian Dental Association or which is clearly experimental in nature;

This is a summary of the benefits available under the Group Insurance Plan. Further details may be obtained from the plan provider.

SECTION III - ENHANCED DRUG/EXTENDED HEALTH PLAN

Extended Health Coverage

This benefit helps pay the cost of eligible medical expenses incurred by an Insured and their insured family members. An Insured will be reimbursed for eligible expenses not covered by the Provincial Medicare Plan, subject to the deductible, if any, and percentage reimbursed shown below. Payment will be made for those eligible expenses which are a) reasonable and medically necessary and b) incurred on the prior recommendation of a legally qualified physician except where otherwise indicated.

ELIGIBLE EXPENSES (IN PROVINCE)

ClaimSecure will pay 100% of Vision Care eligible expenses and 80% of all other eligible expenses unless otherwise indicated. The following are the eligible expenses provided in the province the expense is incurred in.

AMBULANCE

a) A licensed ground ambulance when used to transport an Insured because of emergency or in-patient treatment i) from the place where the Insured suffers the sickness to the nearest hospital where adequate medical treatment is available, ii) from one hospital to another, or iii) from a hospital to the Insured's residence, when an Insured's condition warrants it.
b) Emergency transportation by a licensed air ambulance to the nearest hospital where adequate treatment is available or to another hospital when certified as essential by the attending physician. If medically necessary, in flight services of a registered nurse and the return air fare for the registered nurse will be included.

PARAMEDICAL PRACTITIONERS

$30.00 per treatment to a maximum of $400.00 each policy year for each type of practitioner listed below:

a) Combined services of a clinical psychologist or speech therapist;
b) Combined services of a naturopath or a chiropractor;
c) Services of a registered massage therapist, if recommended by a physician;

$50.00 per treatment to a maximum of $450.00 each policy year for each type of practitioner listed below:

a) Services of a physiotherapist.

ORTHOPEDIC SUPPLIES

Charges for molded arch supports, orthopedic supplies and custom made orthopedic shoes are covered at 80% to a maximum of $200.00, if recommended by a physician, podiatrist or chiropodist;

- Orthopedic supplies as noted above must be dispensed by one of the following providers: orthotist, pedorthist, podiatrist or chiropodist.
- Orthopedic supplies must be dispensed by a different provider than the prescriber.
- Orthopedic supplies prescribed or dispensed by a chiropractor are not eligible.

*When submitting your claim be sure to include the following: Your major medical expense claim form, referral pre-dating treatment, original paid in full invoice, gait analysis or biomechanical exam, a description of the raw materials used in the construction of the orthotic.

PROSTHETIC APPLIANCES

a) Charges for artificial limbs when the loss of the limb occurs while the individual is insured under this benefit, the cost of repair is also eligible; replacement is included when required due to physiological change, but excluding myoelectric appliances;
b) Charges for artificial eyes including reimbursement for one polishing or one remaking of the artificial eye each policy year;
c) Charges for crutches, casts, splints, trusses and braces (does not include dental braces, or expense of a brace or similar device used for non therapeutic purposes or used solely for the purpose of participation in sports or other leisure activities, braces must have rigid or semi rigid materials in them), including replacements when medically necessary;
d) Purchase of an external breast prosthesis when required because of a total or radical mastectomy that has been performed while the individual is insured under this benefit, including the purchase of 2 surgical brassieres, to a maximum of $200.00 per individual each policy year.

MEDICAL SUPPLIES

Charges for compound serums, colostomy supplies, injectible drugs and varicose vein injections, if medically necessary. Such drugs or supplies must be either administered by a physician or dentist or prescribed by a physician or dentist and dispensed by a pharmacist. However, any charges for their administration will not be included.

EQUIPMENT RENTAL

Charges for wheelchairs, walkers, hospital beds, traction kits which are rented for temporary therapeutic use. If, due to extended illness or disability, the need for these items will be long term, the Company, at its sole discretion, may approve the purchase of these items. Repair to a wheelchair will be included up to a lifetime maximum of $250.00.

OTHER ELIGIBLE EXPENSES

a) Charges for oxygen, blood or blood products and the equipment required for its administration;
b) Charges for treatment of a sickness by the use of radiotherapy or coagulotherapy;
c) Charges for laboratory tests done in a commercial laboratory for diagnosis of a sickness but excluding any tests performed in a physician's office or a pharmacy.

VISION CARE

If an Insured incurs expenses for vision care, the Company will pay reasonable and customary charges for:

a) one general optometric examination by an optometrist or ophthalmologist during any 24 consecutive months based on date of first paid claim, to a maximum of $85.00 plus (b) or (c) below;
b) standard eye glass lenses and frames (single vision or bifocal as required) or contact lenses when prescribed by a physician or an optometrist, or replacement of existing eye glass lenses and frames to a maximum of $250.00 in any consecutive 24 months based on date of first paid claim for one complete set of lenses and frames for any one Insured; or
c) contact lenses when prescribed by a physician or optometrist for severe corneal astigmatism, severe corneal scarring, Keratoconus (Conical Cornea) or Aphakia, provided that visual acuity can be improved to at least 20/40 level with contact lenses, but cannot be improved to that level with regular glasses, up to a maximum of $250.00 for one complete set of lenses for any Insured, in any 24 consecutive months based on date of first paid claim. Otherwise, contact lenses are subject to the same maximum as eye glasses and frames.

The Company shall not be liable for any expenses incurred for the provision of sunglasses, safety glasses or any form of eyeglasses provided for cosmetic or aesthetic purposes.

LIMITATIONS AND EXCLUSIONS

a) expenses as a result of any injury or sickness caused by declared or undeclared war or any act thereof;
b) expenses of any kind which would not normally be charged to the Insured provided by the policy were not in effect;
c) expenses incurred from any injury or sickness sustained as a result of employment when the Insured is covered or eligible to receive benefits under the applicable Workplace Safety and Insurance Board's legislation or similar law;
d) expenses as a result of suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
e) cosmetic medical or surgical care, other than due to an accidental bodily injury sustained while the Insured is insured under this benefit;
f) medical treatment which is experimental or investigational in nature;
g) periodic health examinations, broken appointments, physician's costs for traveling or providing telephone advice, third-party examinations, completion of forms or medical reports, travel for health purposes;
h) services, treatment or supplies not included in this benefit;
i) expenses incurred from any injury or sickness as the result of active full-time service in the armed forces of any country;
j) expenses for optical services rendered by a Physician, Licensed, Certified or Registered optician, Licensed, Certified or Registered optometrist or a Licensed, Certified or Registered ophthalmologist employed or engaged by the Fanshawe College;
k) expenses incurred by an Insured who is not covered under any Federal or Provincial Hospital or Medical Plan, or its equivalent.

Accident Benefits

(Applies to all benefit plans)

PRINCIPAL SUM: $15,000

TABLE OF LOSES

Loss	Amount Payable
For loss of:	
Life	1/3 principal sum
Both hands	the principal sum
Both feet	the principal sum
Sight of both eyes	the principal sum
One hand and one foot t	the principal sum
One hand and sight of one eye	the principal sum
One foot and sight of one eye	the principal sum
Speech and hearing in both ears	the principal sum
One arm	3/4 principal sum
One leg	3/4 principal sum
One hand	1/2 principal sum
One foot	1/2 principal sum
Sight of one eye	1/2 principal sum
Speech	1/2 principal sum
Hearing in both ears	1/2 principal sum
Thumb and index finger	1/9 principal sum
Any one finger	1/30 principal sum
For loss of use of:	
Both arms and both legs (quadriplegia)	2 X the principal sum
Both legs (paraplegia)	2 X the principal sum
One arm and one leg on the same side of the body (hemiplegia)	2 X the principal sum
One arm and one leg on different sides of the body	the principal sum
Both arms	the principal sum
Both hands	the principal sum
One hand and one leg	the principal sum
One arm	3/4 principal sum
One leg	3/4 principal sum
One hand	1/2 principal sum

IN THE TABLE OF LOSSES:

Dismemberment loss
Loss by dismemberment means:

a) for hands and feet, complete severance through or above the wrist or ankle joints;
b) for arms and legs, complete severance through or above the elbow or knee joints;
c) for thumb and big toe, complete severance of one entire phalange;
d) for fingers and other toes, complete severance of two entire phalanges.

Surgical reattachment
An amount equal to 50% of the dismemberment benefit is payable if a dismembered part is surgically reattached, regardless of the use regained. The balance of the dismemberment benefit is payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Sight, speech, and hearing loss
Loss of sight, speech, or hearing means total and irrecoverable loss beyond correction by surgical or other means.

Loss of use
Loss of use means total and irrecoverable loss of the ability to perform every action the arm, leg, or hand was able to perform before the accident occurred, beyond correction by surgical or other means. No benefits will be paid for loss of use if benefits for loss by dismemberment of the same arm, leg, or hand are paid or payable as a result of the same accident.

REPATRIATION BENEFIT
If benefits are payable under this benefit provision for loss of life which occurred at least 150 kilometres from the person's place of residence, Canada Life will pay the actual expense incurred for preparation of the body and its transportation to the place of burial or cremation. The maximum amount payable under this provision is $2,500.

EDUCATIONAL BENEFIT FOR DEPENDENT CHILDREN

If benefits are payable under this benefit provision for loss of a student's life, Canada Life will pay the tuition fees for enrolling his dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must satisfy one of the following conditions:

1) he must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing the loss of life; or
2) he must have been enrolled as a full-time student at the secondary school level at the time of the accident causing the loss of life and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

The maximum amount payable under this provision for each year of full-time post-secondary school enrolment is the lesser of:

1) 5% of the principal sum; and
2) $5,000.

Canada Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

Dependent child

A dependent child is an unmarried natural, adopted, or step child of the student or the student's spouse.

A child of the student's spouse is not considered a dependent child unless:

1) he is also the student's child; or
2) the spouse is living with the student and has custody of the child.

Full-time student

A child is considered a full-time student if:

1) he is in registered attendance for 15 hours a week or more; and
2) he is under age 25.

Post-secondary institution

A post-secondary institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level.

Benefit limitations

No benefits will be paid for:

1) tuition expenses incurred before the accident.
2) room or board or other ordinary living, travelling, or clothing expenses.

FAMILY TRANSPORTATION BENEFIT

If a person is hospitalized more than 150 kilometres from his home as a result of a covered loss for which benefits are payable under this benefit provision, Canada Life will pay for transportation and lodging expenses for one family member to join the person. The maximum amount payable under this provision is $2,000.

Benefit limitations

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometre travelled.

OCCUPATIONAL TRAINING BENEFIT FOR SPOUSES

If benefits are payable under this benefit provision for loss of a student's life, Canada Life will pay for expenses associated with his spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify. The maximum amount payable under this provision is the lesser of:

1) 10% of the principal sum; and
2) $10,000.

Spouse

→ A spouse is the student's legal spouse or common-law spouse.
→ A legal spouse means the person lawfully married to the student according to applicable provincial legislation.
→ A common-law spouse means a person who is living with the student in a conjugal relationship.

Benefit limitations

No benefits will be paid for:

1) expenses incurred more than 3 years after the accident causing the loss of life.
2) room or board or other ordinary living, travelling, or clothing expenses.

EDUCATIONAL BENEFIT

If benefits are payable under this benefit provision for a loss that requires the person to change occupations, Canada Life will pay the tuition fees for enrolling the person as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, the person must enrol at a post-secondary institution within 365 days after the accident. The maximum amount payable under this provision is $10,000.

Post-secondary institution

A post-secondary institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level.

Benefit limitations

No benefits will be paid for:

1) tuition expenses incurred before the accident.
2) expenses incurred more than 2 years after the accident causing the loss.
3) room or board or other ordinary living, travelling, or clothing expenses.

WHEELCHAIR BENEFIT

If benefits are payable under this benefit provision for a loss due to an injury that requires the use of a wheelchair for the person to be ambulatory, Canada Life will pay for expenses associated with:

1) alterations to the person's principal residence to make it wheelchair accessible and habitable; and
2) modifications to a motor vehicle used by the person to make it accessible to and driveable by the person.

Benefits for home alterations are payable only if the person or persons making the changes are:

1) experienced in home alterations for wheelchairs; and
2) recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if:

1) the person or persons making the changes are experienced in vehicle modification for wheelchairs; and
2) the modifications are approved by the provincial vehicle licensing authority.

Benefit maximum
The maximum amount payable for all home and vehicle modifications combined is $10,000.

Benefit limitations
No benefits will be paid for:

1) expenses incurred more than 365 days after the accident.
2) subsequent alterations to the person's home or vehicle after an initial claim for benefits has been made under this provision.

GENERAL LIMITATIONS
No benefits will be paid for loss resulting from or associated with the following:

1) suicide or intentionally self-inflicted injury, regardless of the person's state of mind and whether or not he was able to understand the nature and consequences of his actions;
2) viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed;
3) disease or infirmity;
4) medical or surgical treatment, except surgical reattachment;
5) service, including part-time or temporary service, in the armed forces of any country;
6) war, insurrection, or voluntary participation in a riot;
7) air travel, ascent, or descent, except as a passenger in a licensed aircraft flown by a pilot certified to fly the aircraft. Under no circumstances will benefits be paid where the aircraft is owned, leased, or rented by the Group Policyholder or where the person who suffers the loss is acting as a crew member;
8) an accident occurring while operating a vehicle, vessel or aircraft, while the person is impaired by drugs or alcohol, and has a blood alcohol level higher than 80 mg of alcohol per 100 ml of blood;
9) use of any prohibited substance including, but not limited to, any substance listed under the Controlled Drugs and Substance Act, it's Schedules, or other comparable criminal legislation;
10) parachuting or skydiving;
11) participation in a criminal offence or provoking an assault;
12) a loss incurred by a person in their home country or resulting from an accident that occurred in a person's home country, if their home country is not Canada.

PROOF OF CLAIM

Benefits under this policy will be paid only after Canada Life has received satisfactory proof that payment is due.

Claimant responsibility

The claimant must provide information required to prove his entitlement to benefits and must also authorize Canada Life to obtain information from other sources for this purpose.

Time limit

Canada Life will not be liable for benefits for which proof is submitted more than 15 months after the date of the loss.

QUEBEC TIME LIMIT FOR THE PAYMENT OF BENEFITS

Where Quebec law applies, benefits will be paid in accordance with the terms set out in this policy within 60 days following receipt of the required proof of claim.

LEGAL ACTIONS

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

BENEFICIARY

A student may make, alter or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary the student made under the Group Policyholder's previous policy prior to the effective date of this policy applies to this policy until the student makes a change to that designation.

Drug/Dental/EHC/Accident Claims

All practitioners must be licensed, certified or registered, is neither an Insured, or a member of the immediate family and does not ordinarily reside in the Insured's residence.

Please note that general prescription drug and dental claims for the 2025-2026 policy year must be RECEIVED by ClaimSecure no later than November 30, 2026 to be eligible for reimbursement.

How do I make a drug/dental/ehc claim?
Your student identification card may be used at any participation provider (pharmacist or dental office) across Canada and payment of eligible claims will be honored. To fill a prescription drug/dental claim you will need to supply the pharmacist/dentist with the following information:

Your Group Number is 514560
Provider: ClaimSecure (formerly RxPlus)
Your Student ID #R _ _ _ _ _ _ _ _ _ (10 digit alpha numeric number)
I.E. If your student ID # is 7 digits, the correct ID # would be R007654321
At this point you will be required to pay the deductible amount of your claim if necessary

*** Extended health care and vision claims must be mailed to the insurer using a major medical and/or vision care claim form.**

My student card was not accepted at the pharmacy. Why? What do I do?
There are a few different reasons for having complications at your pharmacy. Below are some scenarios:

a) At the beginning of each semester, a listing of all registered and eligible students to date is provided. These records are used to put your personal information on-line at the pharmacy so you can make a pay-direct claim. There is a time period therefore, when you will not be able to use your student card to make an on-line claim due to the transfer of this information to the on-line system at ClaimSecure. If you are affected by this delay, please use the manual reimbursement system as noted below.
b) Your pharmacist may not be familiar with the procedure for processing a prescription claim through ClaimSecure. All pharmacies displaying the ClaimSecure sign will have access to a pharmacist toll free number for the ClaimSecure Call Centre that they can use to assist you on the spot.
c) If you experience complications at the pharmacy that are not related to the above descriptions, please call Alumo for help.

I have been unable to locate a ClaimSecure participating pharmacy. What do I do?
It will be necessary for you to pay the cost of the prescription and keep the official prescription receipt(s) for the total amount. Please use a manual reimbursement system as noted below.

How do I use the manual reimbursement system?
Prescription drug/dental claim forms are available at the FSU Office (SC-1000) or on-line at www.alumo.ca Complete all sections of the form that apply to your claim and once you sign it you can send it along with your receipts directly to ClaimSecure at PO Box 6500 Station A, Sudbury, ON P3A 5N5. It will take approximately 3-4 weeks, depending on mail service, to receive your reimbursement.

Can I submit my claims electronically? Can you reimburse my claim using direct deposit?
YES. Once registered, plan members/dependents can submit claims electronically if you select direct deposit for claim reimbursements. View personal claims history, access dependent claims information (for those individuals under the age of majority), obtain details on the reason for particular claim adjustments or rejections, submit coverage queries online – "Ask the Expert", print individual claims for Co-ordination of Benefits (COB), run consolidated statements for tax purposes, access claim forms and important health information. No application forms to complete, no software, all the plan member/dependent has to do is register online by visiting www.alumo.ca. CLICK on the "eProfie for online claims submission" tab on the webpage.

How do I make an accident claim?
All accident claims should be submitted to Alumo. For more information you can email info@alumo.ca or the FSU Office (SC-1000).

General Inquiries

PLAN OPTIONS
All full time students that have paid the student health plan fee are automatically members of the Balanced plan unless you decide to choose the Enhanced Dental Plan or Enhanced Drug/ Extended Health Plan. To choose a plan other than the Balanced plan please go to our website www.alumo.ca

Am I covered? What is the effective date of my coverage?
Full-time post secondary registered students are automatically enrolled in the health plan for September 1.

May I enroll my dependents?
Students who are on the Health Insurance Plan, may obtain coverage for their spouse and dependent children by enrolling them before September 21, 2026 at 4:00 pm for the fall semester, January 18, 2027 at 4:00 pm for the winter semester, or May 14, 2027 at 4:00 pm for the summer semester and paying the appropriate fee indicated on the form. You can register on www.alumo.ca.

"SPOUSE" means the legal spouse of the Insured Student, residing in Canada, provided there is no legal separation in effect, or an individual of the same sex or opposite sex who has been residing with the Insured Student for a period of at least one year and who has been designated as the spouse of the Insured Student in Fanshawe College's records for insurance purposes, and is covered under the provincial health insurance plan.

"DEPENDENT CHILD OR CHILDREN" means any natural child, step child or legally adopted child of the Insured Student, who is 20 years of age and under, unmarried and receives full support and maintenance from the Insured Student, or 21 years of age but less than 25 years of age, unmarried and receives full support and maintenance from the Insured Student for reason of full-time attendance at an accredited institute, college or university in Canada or receives full support and maintenance from the Insured Student by reason of mental or physical infirmity, a resident of Canada, and is covered under the provincial health insurance plan.

Please be aware that should you decide to purchase family benefits for your spouse and/or dependant children they will also be enrolled in the same benefit plan that you have chosen and for the same time period you are active during the policy year.

What if I am already covered?
Should you not wish to co-ordinate benefits with your other plan, you are able to decline coverage for the health plan benefit by processing an Online Opt-Out Form. All eligible refunds will be completed by direct deposit.

Please be aware you must opt-out prior to the deadline date of your first semester. For example: If you are a September start student and missed the deadline to opt-out of September 21, 2026 at 4:00 pm, you are not able to opt-out of the plan in January. Please see deadline dates below.

If you are a September start student the Deadline to opt-out is September 21, 2026 at 4:00 pm.

If you are a January start student the Deadline to opt-out is January 18, 2027 at 4:00 pm.

If you are a May start student the Deadline to opt-out is May 14, 2027 at 4:00 pm.

To complete your health plan benefits Online opt-out please go to www.alumo.ca.

Should you choose to opt-out of the plan, you only need to fill out this form once for the entire year. Once you have opted out of the plan you are NOT eligible to opt back into the plan at any point in the policy year (If you have extenuating circumstances and your current health coverage changes please contact the FSU Office (SC-1000)\519-452-4109 to enquire about your options).

Please note: The above noted Deadline Dates will not be extended. Should you miss this date, no refund will be issued even if the dental coverage has not been used. Should there be a dispute as to a student having applied for but not receiving an opt-out refund it will be the responsibility of the student to provide their online opt-out confirmation receipt to the FSU Office (SC-1000) In the instance that a student is unable to provide the FSU Office (SC-1000) with their online Opt-Out confirmation receipt, no reimbursement will be issued.

What is the termination date of my coverage?
Students who are full-time attending and have paid for the health plan for two semesters will have a termination date of August 31, 2027. For full-time attending students that are only enrolled for one semester your coverage will terminate at the end of the policy year.
i.e. If you're a September start student, your coverage will run from September 1, 2026 through August 31, 2027. For all students once your coverage terminates, any additional family coverage that you have applied for will terminate also.

Termination of Insurance
Insurance with respect to each Insured Person will immediately terminate on the earliest of the following dates:

a) The date this policy is terminated.
b) The date the Insured Student becomes insured under a policy replacing this policy.
c) The date an Insured Student ceases to be associated with the Policyholder in a capacity making such person eligible for insurance hereunder.
d) The date an Insured Student reaches 79 years of age.

Insurance, with respect to a Spouse or Dependent Child or Children of the Insured Student shall terminate on the date the insurance of an Insured Student terminates or on the date the Spouse or Dependent Child or Children cease to qualify for insurance hereunder in accordance with the definitions, whichever date shall first occur.

Coordination of Benefits for Private and Provincial Plans
Amounts payable under the policy shall only be for the excess of such expenses over any amounts available or collectible for the treatment or services which are insured services under the Provincial Medical or Hospital Care Plan of the province in which the Insured is resident, whether or not the Insured is covered hereunder.

If an Insured has coverage under another plan of insurance which provides similar benefits, the order of benefits determination is as follows:

a) the plan that does not include a Co-ordination of Benefits provision is considered to be the primary plan and pays benefits first before a plan which includes a Coordination of Benefits provision
b) the plans that include a Co-ordination of Benefits provision, priority payment is established as follows:
    1. the plan where the Insured is covered as a student
    2. the plan where the Insured is covered as a dependent

If you have any questions, contact Alumo at 519-913-3701

This brochure is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an Insured will be governed solely by the Group Master Policy issued by ClaimSecure.

Your Drug/Dental/EHC Claims are paid by ClaimSecure

When making a pay direct drug/dental claim the pharmacy/dentist will need to know the following

- Your Group Number 514560
- Provider: ClaimSecure {formerly RxPlus/Merx Health Corporation)
- Your Student ID # R 0 0 _ _ _ _ _ _ _ _
  (10 digit alpha numeric number)

I.E. If your student ID # is 7 digits, the correct ID # would be R001234567

All Dental Inquiries call Toll Free 1-888-513-4464

*If mailing your claim please mail your prescription drug/dental/EHC claim directly to ClaimSecure at PO Box 6500 Station A, Sudbury, ON, P3A SNS
**If tracking your claims on-line please visit www.claimsecure.com

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Plan Consultants:

ALUMO

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