

ALUMO

POWERED BY YOUR
nCSAC

2026-2027

Student Insurance Plan

NCSAC
Sponsored
Benefits

Policy: 181892

Designed for the students
of Niagara College

All eligible students that have paid
the health plan fee are automatically
enrolled in the Balanced Plan.



ALUMO

**Questions? Call Alumo:
905-346-1667**

Please have your student ID readily available.

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

www.alumo.ca

underwritten by:

**Canada Life, administered by Alumo
(hereinafter referred to as The Company”)**

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SECTION I - BALANCED PLAN

Prescription 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 \$5,000.00 per Insured, per policy year, for expenses for:

- a) most prescription drugs or medicines;
- b) insulin injectibles;
- c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of \$400.00 per Insured per policy year (Pseudo Din# 910333 must be used for all diabetic supplies.);
- d) hepatitis B vaccine, subject to a maximum of \$100.00 per Insured, per policy year;
- e) preventative vaccines;
- f) allergy serums;
- g) oral contraceptives, the contraceptive patch (birth control); IUD's;
- h) Nuva Ring (contraceptive), subject to a maximum of \$178.00 per Insured per policy year;
- i) all acne preparations excluding Accutane;
- j) Zyban and/or Champix, subject to a lifetime maximum of \$500.00.

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 \$8.00. 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; injectible 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) Accutane.

SECTION I - BALANCED PLAN

Dental Coverage

MAXIMUM COVERAGE

During each policy year, the maximum coverage per Insured is \$500.00.

Reimbursement is considered according to the current Ontario Dental Association's Suggested Fee Guide for General Practitioners.

***Additional discounts may be 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

75% of the cost of amalgam, silicate, composite or tooth-coloured fillings and space maintainers.

Please note the following information:

- 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

75% coverage of extractions and residual root removal, limited to two wisdom teeth in

any policy year after 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 five 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 five 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 three 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) orthodontics;
- d) dental braces;
- e) cosmetic surgery or treatment when classified as such by the Company;
- f) 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. 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)

100% of Vision Care eligible expenses and 80% of all other eligible expenses, unless otherwise indicated.

The following are the eligible expenses provided by licensed practitioners 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

80% up to a maximum of \$300.00 each policy year for each type of practitioner listed below:

- a) Combined services of a clinical psychologist (including RSW and MSW social workers) or speech therapist, if recommended by a physician;
- b) Combined services of a naturopath or a chiropractor;
- c) Combined services of a dietitian and/or nutritionist;
- d) Services of an acupuncturist;
Practitioners must be registered with; Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
- e) Services of a Osteopath;
- f) Services of a registered massage therapist, if recommended by a physician;
- g) Services of a physiotherapist, if recommended by a physician.

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 re-making 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, injectable 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.

BREATHING EQUIPMENT

- a) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) machines are covered to a combined maximum of \$1,250.00 per person per lifetime;
- b) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) supplies are covered to a combined maximum of \$500.00 per person per policy year.

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, 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 \$50.00 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 \$125.00 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) vaccines; 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 Niagara 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 DRUG/VISION PLAN

Prescription 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 \$6,000.00 per Insured, per policy year, for expenses for:

- a) most prescription drugs or medicines;
- b) insulin injectibles;
- c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of \$400.00 per Insured per policy year (Pseudo Din# 910333 must be used for all diabetic supplies.);
- d) hepatitis B vaccine, subject to a maximum of \$100.00 per Insured, per policy year;
- e) preventative vaccines;
- f) allergy serums;
- g) oral contraceptives, the contraceptive patch (birth control); IUD's;
- h) Nuva Ring (contraceptive), subject to a maximum of \$178.00 per Insured per policy year;
- i) all acne preparations excluding Accutane;
- j) Zyban and/or Champix, subject to a lifetime maximum of \$500.00.

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 \$8.00. 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; injectible 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) Accutane.

SECTION II - ENHANCED DRUG/VISION PLAN

Dental Coverage

MAXIMUM COVERAGE

During each policy year, the maximum coverage per Insured is \$350.00.

Reimbursement is considered according to the current Ontario Dental Association's Suggested Fee Guide for General Practitioners.

***Additional discounts may be available through the Dental Network.**

Please visit www.alumo.ca for more information.

BASIC AND PREVENTIVE SERVICES

80% 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)

80% 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:

- 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 after any policy year.

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) orthodontics, endodontics, periodontics, crowns, bridges, dentures;
- d) dental braces;
- e) cosmetic surgery or treatment when classified as such by the Company;
- f) 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 DRUG/VISION PLAN

Extended Health Coverage

This benefit helps pay the cost of eligible medical expenses incurred by an Insured. 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)

100% of Vision Care eligible expenses and 80% of all other eligible expenses, unless otherwise indicated.

The following are the eligible expenses provided by licensed practitioners 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

65% up to a maximum of \$300.00 each policy year for each type of practitioner listed below:

- a) Combined services of a naturopath or a chiropractor;
- b) Combined services of a dietitian and/or nutritionist;
- c) Services of an acupuncturist;
Practitioners must be registered with; Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
- d) Services of a Osteopath;
- e) Services of a registered massage therapist, if recommended by a physician;
- f) Services of a physiotherapist, if recommended by a physician.

65% up to a maximum of \$200.00 each policy year for each type of practitioner listed below:

- a) Combined services of a clinical psychologist (including RSW and MSW social workers) or speech therapist, if recommended by a physician.

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 re-making 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, injectable 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.

BREATHING EQUIPMENT

Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) machines are covered to a combined maximum of \$1,250.00 per person per lifetime;

- a) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) supplies are covered to a combined maximum of \$500.00 per person per policy year.

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, 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 \$150.00 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 \$150.00 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) vaccines; 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 Niagara 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 DENTAL/VISION PLAN

Prescription 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 70% of the reasonable and customary charges incurred, to a maximum of \$1,500.00 per Insured, per policy year, for expenses for:

- a) most prescription drugs or medicines;
- b) insulin injectibles;
- c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of \$400.00 per Insured per policy year (Pseudo Din# 910333 must be used for all diabetic supplies.);
- d) hepatitis B vaccine, subject to a maximum of \$100.00 per Insured, per policy year;
- e) preventative vaccines;
- f) allergy serums;
- g) oral contraceptives, the contraceptive patch (birth control);
- h) Nuva Ring (contraceptive), subject to a maximum of \$178.00 per Insured per policy year;
- i) all acne preparations excluding Accutane;
- j) Zyban and/or Champix, subject to a lifetime maximum of \$500.00.

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 \$8.00. 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) contraceptives, other than oral, contraceptive patch and the Nuva Ring; oral vitamins; injectible 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) Accutane.

SECTION III - ENHANCED DENTAL/VISION PLAN

Dental Coverage

MAXIMUM COVERAGE

During each policy year, the maximum coverage per Insured is \$750.00.

Reimbursement is considered according to the current Ontario Dental Association's Suggested Fee Guide for General Practitioners.

***Additional discounts may be 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:

- 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, limited to two wisdom teeth in any policy year.

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) orthodontics, endodontics, periodontics, crowns, bridges, dentures;
- d) dental braces;
- e) cosmetic surgery or treatment when classified as such by the Company;
- f) 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 DENTAL/VISION PLAN

Extended Health Coverage

This benefit helps pay the cost of eligible medical expenses incurred by an Insured. 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)

100% of Vision Care eligible expenses and 80% of all other eligible expenses, unless otherwise indicated.

The following are the eligible expenses provided by licensed practitioners 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

60% up to a maximum of \$300.00 each policy year for each type of practitioner listed below:

- a) Combined services of a naturopath or a chiropractor;
- b) Combined services of a dietitian and/or nutritionist;
- c) Services of an acupuncturist;
Practitioners must be registered with; Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
- d) Services of a Osteopath;
- e) Services of a registered massage therapist, if recommended by a physician;
- f) Services of a physiotherapist, if recommended by a physician.

60% up to a maximum of \$200.00 each policy year for each type of practitioner listed below:

- a) Combined services of a clinical psychologist (including RSW and MSW social workers) or speech therapist, if recommended by a physician.

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 re-making 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, injectable 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.

BREATHING EQUIPMENT

- a) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) machines are covered to a combined maximum of \$1,250.00 per person per lifetime;
- b) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) supplies are covered to a combined maximum of \$500.00 per person per policy year.

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, 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 \$175.00 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 \$175.00 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) vaccines; 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 Niagara College;
- k) expenses incurred by an Insured who is not covered under any Federal or Provincial Hospital or Medical Plan, or its equivalent.

Prescription 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 70% 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 injectibles;
- c) insulin supplies which include syringes, needles and diagnostic test strips, including glucometers, alcohol swabs and lancets, subject to a maximum of \$400.00 per Insured per policy year (Pseudo Din# 910333 must be used for all diabetic supplies.);
- d) hepatitis B vaccine, subject to a maximum of \$100.00 per Insured, per policy year;
- e) preventative vaccines;
- f) allergy serums;
- g) oral contraceptives, the contraceptive patch (birth control); IUD's;
- h) Nuva Ring (contraceptive), subject to a maximum of \$178.00 per Insured per policy year;
- i) all acne preparations excluding Accutane;
- j) Zyban and/or Champix, subject to a lifetime maximum of \$500.00.

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 \$8.00. 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; injectible 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) Accutane.

Dental Coverage

MAXIMUM COVERAGE

During each policy year, the maximum coverage per Insured is \$400.00.

Reimbursement is considered according to the current Ontario Dental Association's Suggested Fee Guide for General Practitioners.

***Additional discounts may be available through the Dental Network.**

Please visit www.alumo.ca for more information.

BASIC AND PREVENTIVE SERVICES

85% 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)

85% 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:

- 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 after any policy year.

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) orthodontics, endodontics, periodontics, crowns, bridges, dentures;
- d) dental braces;
- e) cosmetic surgery or treatment when classified as such by the Company;
- f) 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 IV - ENHANCED EXTENDED HEALTH CARE/VISION PLAN

Extended Health Coverage

This benefit helps pay the cost of eligible medical expenses incurred by an Insured. 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)

100% of Vision Care eligible expenses and 80% of all other eligible expenses, unless otherwise indicated.

The following are the eligible expenses provided by licensed practitioners 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

100% up to a maximum of \$400.00 each policy year for each type of practitioner listed below:

- a) Combined services of a naturopath or a chiropractor;
- b) Combined services of a dietitian and/or nutritionist;
- c) Services of an acupuncturist;
Practitioners must be registered with; Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
- d) Services of a Osteopath;
- e) Services of a registered massage therapist, if recommended by a physician;
- f) Services of a physiotherapist, if recommended by a physician;
- g) Combined services of a clinical psychologist (including RSW and MSW social workers) or speech therapist, if recommended by a physician.

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 re-making 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, injectable 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.

BREATHING EQUIPMENT

- a) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) machines are covered to a combined maximum of \$1,250.00 per person per lifetime;
- b) Continuous positive airway pressure (CPAP), Variable Positive Airway Pressure (VPAP) and Automatically-adjusting Positive Airway Pressure (APAP) supplies are covered to a combined maximum of \$500.00 per person per policy year.

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, 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) vaccines; 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 Niagara 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

For loss of:

Life

Both hands

Both feet

Sight of both eyes

One hand and one foot

One hand and sight of one eye

One foot and sight of one eye

Speech and hearing in both ears

One arm

One leg

One hand

One foot

Sight of one eye

Speech

Hearing in both ears

Thumb and index finger

Any one finger

Amount Payable

1/3 principal sum

the principal sum

the principal sum

the principal sum

the principal sum

the principal sum

the principal sum

the principal sum

3/4 principal sum

3/4 principal sum

1/2 principal sum

1/2 principal sum

1/2 principal sum

1/2 principal sum

1/2 principal sum

1/9 principal sum

1/30 principal sum

For loss of use of:

Both arms and both legs

(quadriplegia)

Both legs (paraplegia)

One arm and one leg on the same

side of the body (hemiplegia)

One arm and one leg on

different sides of the body

Both arms

Both hands

One hand and one leg

One arm

One leg

One hand

2 X the principal sum

2 X the principal sum

2 X the principal sum

the principal sum

the principal sum

the principal sum

the principal sum

3/4 principal sum

3/4 principal sum

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 enrolls 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, its 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.

TUITION INSURANCE BENEFIT

(Applies to all benefit plans)

Industrial Alliance Insurance and Financial Services Inc. agrees to pay the amount of insurance if the Insured Student should become disabled or die while covered under this insurance benefit. Any payment made in good faith at the time of payment shall fully discharge Industrial Alliance Insurance and Financial Services Inc. of any liability for the amount of such payment under this benefit.

For the purposes of this benefit, “disabled” and “disability” shall mean a severe and prolonged disability due to injury or illness that lasts for a continuous period of no less than 60 days and requires that the Insured Student completely withdraw from all classes and not attain the credits from the academic institution. Furthermore, the Insured Student must be receiving continuous and appropriate medical treatment from a medical practitioner who is not related to the Insured Student, beginning from the onset of the injury or illness.

AMOUNT OF INSURANCE

In the event of death or disability of the Insured Student, the Plan will reimburse the cost of:

- any non-refundable tuition fees, including ancillary fees, for the current semester, up to a maximum of:
 - i) **\$10,000 in the event of a disability where the Insured Student has to abandon studies;**
 - ii) **\$5,000 in the event of the Insured Student’s death;**
- textbooks purchased for the current semester, up to a maximum of \$1,000.

With respect to the reimbursement of non-refundable tuition fees, only those tuition fees that are mandatory and non-negotiable are eligible for reimbursement.

For ancillary fees, the benefit reimbursed is calculated on a pro-rata basis for the portion of the academic period from the date the Insured Student withdrew from school to the end of the academic period in which the fees were paid.

Any eligible amount refunded to the Insured Student from the academic institution will be subtracted from the Insured Student’s reimbursement amount under this benefit.

The overall maximum benefit payable under this benefit is \$10,000 per lifetime per Insured Student.

BENEFICIARY IN THE EVENT OF THE INSURED STUDENT'S DEATH

Insurance payable in the event of the loss of life of a Participant is payable to the parent or guardian, where the Participant is a minor.

If the Participant is married, such indemnity is payable to the Spouse, unless otherwise designated in writing and on file with the Policyholder. If the Participant is not a minor and is unmarried, such indemnity is payable to the parent, unless otherwise designated in writing and on file with the Policyholder. If there is no such beneficiary designation, nor is there a parent, such indemnity is payable to the estate of the Participant.

EXCLUSIONS AND LIMITATIONS

This benefit does not cover disability or death resulting from:

- a) Drug or narcotic use, except as prescribed by and while under the care of a doctor;
- b) An intentionally self-inflicted sickness or injury, or failure to attend classes for any reason other than sickness or injury;
- c) Death resulting from suicide;
- d) Declared or undeclared war or any act thereof;
- e) A criminal act the Insured Student commits or attempts to commit.

Travel Coverage

(Applies to all benefit plans)

(Emergency out of Province/Canada)

Coverage for Emergency Injury or Sickness

Lifetime Maximum: \$5,000,000

Trip Duration

180 Days maximum

Emergency Out of Province Coverage and Assistance is provided by AIG Insurance Company of Canada Travel Insurance under policy: SRG 9426408

Global Excel

For emergency assistance call 1-866-870-1898

Outside North America, call collect: +819-566-1898

Medical Assistance

YOU MUST contact Global Excel prior to receiving any medical treatment. If you do not, you may receive inappropriate or unnecessary medical treatment, which may not be included in your coverage.

As this coverage is outside of the standard student health plan benefits, please contact your SAC office on campus for further details on this coverage and pick up your Medical Assistance Card or download the Travel Benefits Card and Travel Insurance Booklet form the Booklet & Forms page at www.alumo.ca

Life Insurance Benefit

(Applies to all benefit plans)

Industrial Alliance Insurance and Financial Services Inc. agrees to pay the amount of insurance if the Insured Student should die while covered under this insurance benefit. Any payment made in good faith at the time of payment shall fully discharge Industrial Alliance Insurance and Financial Services Inc. of any liability for the amount of such payment under this benefit.

AMOUNT OF INSURANCE

Amount of insurance: \$10,000

Termination of insurance: The date an Insured Student reaches 65 years of age

BENEFICIARY

Insurance payable in the event of the loss of life of an Insured Student is payable to the parent, or guardian where the Insured Student is a minor. Otherwise, it is payable to the estate of the Insured Student.

CONVERSION PRIVILEGE

If the insurance under this benefit ends because the Insured Student ceases to belong to the group insured while the contract is in force, the Insured Student is entitled to convert all or part of his group life insurance coverage to individual life insurance without having to prove his insurability. To exercise the conversion privilege, the Insured Student must apply in writing to Industrial Alliance Insurance and Financial Services Inc. no later than 31 days after the day he ceases to belong to the group insured.

If the Insured Student ceases to belong to the group on the day he reaches the 65 years of age or earlier, he can opt for one of the following types of individual insurance:

- a) A life insurance that is comparable to his group insurance as to the amount and duration, but that does not exceed \$400,000 for all of his group life insurance benefits combined, including the ones he was insured for as a spouse or child, where applicable
- b) A one-year term life insurance that can be converted into the insurance described in item a) above

If the Insured Student should die during the 31-day period in which he could have exercised his conversion privilege and his group insurance coverage has not already been converted, the amount of life insurance he was eligible to convert shall be payable under the group insurance contract.

In all cases described above, the premium for the first year of the individual insurance cannot exceed the premium for a one-year term insurance. Except for this first-year premium, the premiums must be level for the term of the individual policy. The individual policy premiums are based on the rates in force for individual insurance, in accordance with the gender, age and smoking status of the Insured Student on the date he ceases to belong to the group insured, and in accordance with the particulars that applied to the group life insurance of the Insured Student. Industrial Alliance Insurance and Financial Services Inc. must receive the first premium for individual life insurance within 31 days following the date the Insured Student ceases to belong to the group insured.

EXCLUSIONS AND LIMITATIONS

- a) Suicide, while sane or insane.
- b) Declared or undeclared war or any act thereof.
- c) A criminal act the Insured Student commits or attempts to commit.

BENEFICIARY IN THE EVENT OF THE INSURED STUDENT'S DEATH

Insurance payable in the event of the loss of life of a Participant is payable to the parent or guardian, where the Participant is a minor.

If the Participant is married, such indemnity is payable to the Spouse, unless otherwise designated in writing and on file with the Policyholder. If the Participant is not a minor and is unmarried, such indemnity is payable to the parent, unless otherwise designated in writing and on file with the Policyholder. If there is no such beneficiary designation, nor is there a parent, such indemnity is payable to the estate of the Participant.

STUDENT ASSISTANCE PROGRAM

The Student Assistance Program (SAP) provides eligible students and their dependents with short-term therapy, lifestyle counselling, courses, tools and events to improve mental and physical health.

Access is available 24/7 by phone or virtual resources, worldwide. Care is immediate by connecting with the intake team and there is no level of payment required.

Find more information through www.alumo.ca.

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, dental, and EHC 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? (as of September 1st, 2026)

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

- Group policy number: 181892
- Drug Carrier: 34 (ASSURE)
- Dental CARRIER: 000034
- Your Certificate: Your Student ID (without leading zeros)

At this point you will be required to pay the deductible amount of your claim if necessary.

Please note the dental office may charge more than the Fee Guide, which will require the student to be responsible for any additional costs.

When and where do I get my Family Benefits card?

You apply for family coverage or single parent coverage directly through Alumo on www.alumo.ca. You send payment directly to the broker, Alumo. Once you are registered on the benefit app, the whole family can use the same card.

My student card was not accepted at the pharmacy or dental office.

There are a few different reasons for having complications at your pharmacy or dental office. 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 online so you can make a pay-direct claim at your pharmacy or dental office. There is a time when you will not be able to use your student card to purchase claims on-line due to the transfer of information to the on-line system. If you are affected by this delay, please use the manual reimbursement system as noted below.
- b) Your pharmacist or dentist may not be familiar with the procedure for processing a claim through the Benefits app (Adjudicare).
- 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 participating pharmacy or dental office.**What do I do?**

It will be necessary for you to pay cash for the claim, keeping official receipt(s), which will identify the total amount(s) paid. Please use the manual reimbursement system as noted below.

How do I make an Extended Health Care claim?

Be aware that when making a claim under this benefit, which also includes your vision coverage, you will need to pay 100% of the cost up front and submit a manual claim directly to the Benefits app for reimbursement. Extended Health Care claim forms will also be available at www.alumo.ca.

How do I use the manual reimbursement system?

Go on the www.alumo.ca website select File a Claim or How to Claim and look for Download the Alumo Benefits App section and click Web Registration or, Download on the app and follow the steps to register!

- 1) To register, enter your student ID without letters or leading zeros as the certificate number and the group number. To find your group number, visit www.alumo.ca. Select your school, student association or union and the website will open in a new tab, scroll to the bottom footer where the group number is displayed. You may click Need more Help. Next, enter your last name, postal code and date of birth. Make sure your date of birth and last name match the school records.

- 2) Create a unique username and enter your e-mail address. Create a password following the guidelines on the page and enter it in both the Password and Confirm password fields. Now that the enrollment form is completed, click the Register button at the bottom to submit your registration. Take a moment to read through the terms and conditions, then click I Agree to continue. Check your e-mail for the security code needed to complete your registration.
- 3) Log in to set up your account.
- 4) Enter your mailing address for contact and documentation purposes to ensure accurate processing of your claims and payments. Your account is fully set up. You can now check coverage balance and stay informed with our health solutions and resources.

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), directly on the Benefits app.

How do I make an accident claim?

Contact ALUMO as soon as possible for the procedure.

www.alumo.ca

905-346-1667

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 Drug/Vision Plan or Enhanced Extended Health/Vision Plan or Enhanced Dental/Vision Plan, which must be done yearly. To choose a plan other than the Balanced Plan please go to www.alumo.ca The deadline dates to choose a different plan option run from September 1, 2026 to September 30, 2026 at 4:00pm for September-start students; January 1, 2027 to January 31, 2027 at 4:00pm for January-start students; and May 1, 2027 to May 31, 2027 at 4:00pm for Summer-start students.

Am I covered? What is the effective date of my coverage?

Although you are registered as a full-time student, you may NOT be covered! Co-op terms and program start dates may affect your coverage. Please contact the Student Benefits Coordinator in your NCSAC office to determine your eligibility.

The Health Plan is effective September 1, 2026 to August 31, 2027. The effective date for January runs from January 1, 2027 to August 31, 2027. Also, note that the effective date for May runs from May 1, 2027 to August 31, 2027.

What if I am already covered?

You may decline coverage for the Health and Dental benefits by completing the on-line opt-out application. The opt-out deadline is September 30, 2026 at 4:00 pm for September start programs or January 31, 2027 at 4:00 pm for January start programs or May 31, 2027 at 4:00 pm for May start programs. Please be aware that these deadline dates will not be extended. You must provide proof of similar coverage elsewhere (ie. as a dependant under your parent's or spouse's insurance). Please go to www.ncsac.ca or www.alumo.ca to complete your on-line opt-out application. Opt out refunds will be credited to the students account no later than November 1, 2026 for fall start students, March 1, 2027 for winter start students and June 30, 2027 for spring/summer start students.

What is the termination date of my coverage?

In accordance with the outline described above, your benefits will terminate August 31.

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 70 years of age.

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:

- e) 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 Co-ordination of Benefits provision
- f) 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
905-346-1667**

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 underwritten by Canada Life and administered by Alumo.

NEW FOR 2026-2027:

Your drug, dental, and extended health care claims are covered by Alumo.

PAY DIRECT - THE PHARMACIST/DENTIST WILL NEED TO KNOW:

Canada Life Policy: 181892

Drug Carrier: 34 (ASSURE)

Dental Carrier: 000034 (TELUS AdjudiCare)

Your Certificate ID is your Student ID
(without leading zeros or letters)

Submit claims quickly and easily

Simply open the **Alumo Benefits App** on your web browser or mobile app and click the register button. Visit www.alumobenefitsapp.ca

Claim Inquiries

Contact Alumo Claims

1-866-586-1010

Claims@alumo.ca

Plan Consultants:

ALUMO

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

Website: www.alumo.ca

Email: claims@alumo.ca

Alumo Toll Free: 1-866-586-1010

All Drug, Accident, Dental & EHC Benefits Underwritten by:

Canada Life, Administered by Alumo

