



# PHLY Student Accident Insurance 2023-24

BOWDOIN COLLEGE  
GROUP POLICY NUMBER: PHPA 139537



A Member of the Tokio Marine Group



A Member of the Tokio Marine Group

## Philadelphia Indemnity Insurance Company

Administrative Office  
One Bala Plaza, Suite 100, Bala Cynwyd, PA 19004  
Tel: 800-873-4552

**POLICYHOLDER:** Bowdoin College  
**GROUP POLICY NUMBER:** PHPA139537  
**POLICY EFFECTIVE DATE:** August 1, 2023  
**POLICY EXPIRATION DATE:** August 1, 2024  
**STATE OF ISSUE:** Maine

This Certificate of Insurance is issued under the terms of the Blanket Accident Policy issued to the Policyholder. Coverage is only described in the Certificate of Insurance. It is not the insurance contract. The Policy is the only contract under which benefits are paid. The Policy may be examined, upon request, at the office of the Policyholder.

The Policy sets forth the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the Policyholder's address. It will remain in effect for the duration of the Policy Term shown above if premium is paid according to agreed terms.

The Policy terminates at 12:01 AM on the last day of the Policy Term unless the Policyholder and We have agreed to continue this Policy for an additional Policy Term. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of the Policy.

IN WITNESS WHEREOF Philadelphia Indemnity Insurance Company has caused this Certificate to be executed on its Issue Date, to take effect on the Effective Date.

President & CEO  
Philadelphia Indemnity Insurance Company

Secretary  
Philadelphia Indemnity Insurance Company

• **BLANKET ACCIDENT CERTIFICATE** •  
• **NON-PARTICIPATING** •

**THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY. IT DOES NOT PAY for PAYS LIMITED BENEFITS FOR SICKNESS**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. If you have a Medicare supplement policy or major medical policy, this coverage may be more than you need. For information call the Bureau of Insurance at 1-800-300-5000.**



## SCHEDULE OF BENEFITS

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This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

**Eligible Persons:** All enrolled students of the Policyholder including student coaches, student managers and student trainers who have purchased coverage

### CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages.

School Coverage and Voluntary 24-Hour Coverage  
Personal Deviations covered No

**Covered Activities** 24-hour coverage, including participation in Intercollegiate Sports, while under the Policyholder's jurisdiction

### ACCIDENT INDEMNITY BENEFITS

#### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum \$5,000  
Loss must occur within 365 days of the Covered Accident

#### Schedule of Covered Losses

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	100% of the Principal Sum
Hemiplegia	100% of the Principal Sum
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in Both Ears	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum

**Aggregate Limit of Indemnity** \$100,000  
Applies to: All Conditions of Coverage

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses suffered by all Covered Persons insured under this Accidental Death and Dismemberment Benefit as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. If this amount does not allow all Covered Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

**ACCIDENT MEDICAL EXPENSE BENEFITS**

Any benefit limits and Benefit Percentages for Accident Medical Expense Benefits apply, unless otherwise specified, on a per-Covered Person, per-Covered Accident basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

**Scope of Coverage Applicable to Accident Medical Benefits**

Full Excess Medical Expense

**Medical Expense Benefits**

Total Maximum for all Accident Medical Expense Benefits	\$5,000
First Covered Expenses must be Incurred within	180 days after a Covered Accident
Benefit Period	2 years from the date of the Covered Accident
Deductible	\$ 0
applies to	each Covered Accident
does not	include Covered Expenses paid under another Health Care Plan

**Covered Expenses**

**In-Patient Hospital Services**

Daily ICU or CCU Benefit	100%
Daily In-Hospital Benefit	100% of the average Semi-private room rate
Miscellaneous Services	100% per Hospital Stay

**Ambulatory Medical Center** 100%

**Emergency Room Treatment** 100%

**Physician Services**

Surgery Benefit	100%
Assistant Surgeon	100%
Physician's Surgical Facilities	100%
Second Opinion or Consultation	100%
Physician's Assistant	100%
Anesthesia Benefit	100%
Inpatient Visits	100%
Office Visits	100% per visit

<b>Outpatient X-ray, CT Scan, MRI and Laboratory Tests</b>	100%
<b>Outpatient Physiotherapy</b>	100%
<b>Nursing Services</b>	100%
<b>Ambulance Services</b>	100%
<b>Medical Equipment Rental</b>	100%
<b>Medical Services and Supplies</b>	100%
<b>Dental Services</b>	100%
<b>Prescription Drug Benefit</b>	100%
<b>Home Health Care Benefit</b>	
Calendar Year Deductible	\$0
Home Health Care Visit	100%
Maximum Visits	90 per any continuous period of 12 months
Each visit by an individual member of a home health care provider shall be considered as one home care visit.	
Medical Supplies, Drugs and Medications	100%
<b>Treatment of Alcoholism</b>	100%
<b>EXPANDED MEDICAL BENEFIT FOR COVERED SPORTS CONDITIONS</b>	100%
Covered Sports Conditions	bursitis, sprains, hernia, muscle tears, tendonitis and repetitive motion injuries
<b>HEART AND CIRCULATORY CONDITIONS ENDORSEMENT</b>	
Benefit Percentage	100%
Covered Heart and Circulatory Conditions	heat exhaustion, heart attack, stroke, burst aneurysm

## **SCOPE OF COVERAGE APPLICABLE TO MEDICAL EXPENSE BENEFITS**

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Covered expenses and any applicable Deductibles are shown in the *Schedule of Benefits*.

### **Other Health Care Plan Benefits**

When another Health Care Plan provides benefits in the form of services rather than cash payments, We will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

### **Full Excess Medical Expense**

We will pay Covered Expenses:

1. after the Covered Person has satisfied any applicable Deductible; and
2. only when they are in excess of amounts payable by any Other Health Care Plan whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

Any Covered Expenses payable under this provision will be reduced by the the Other Health Care Plan Reduction Percentage shown in the *Schedule of Benefits* if:

1. the Covered Person has coverage under another Health Care Plan;
2. the Other Health Care Plan is an HMO, PPO or similar arrangement; and
3. the Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement.

Covered Expenses will not be reduced for emergency treatment within 24 hours after a Covered Accident which occurred outside the geographic service area of the HMO, PPO or similar arrangement. This provision only applies when the Covered Person is covered for in-network benefits only.

**Definitions** For purposes of the Accident Medical Benefits provided by this Policy:

**HMO** or Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider or service.

**PPO** or Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform those services at rates lower than non-Preferred Providers.

## **GENERAL DEFINITIONS**

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Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

**Benefit Percentage** means the percentage of Covered Expenses We pay that are Incurred by the Covered Person after he satisfies any applicable Deductible. Benefit Percentages are shown in the *Schedule of Benefits*.

**Certificate** means the evidence of the Covered Person's coverage under this Policy. Coverage is subject to the Policy provisions. The Certificate is not the Policy.

**Company** or **We, Us, Our**, means Philadelphia Indemnity Insurance Company, domiciled in Pennsylvania.

**Covered Accident** means a sudden, unforeseeable event that results, directly and independently of all other causes, in an injury or loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;

2. is not contributed to by: disease; sickness; or mental or bodily infirmity; and
3. is not otherwise excluded under the terms of this Policy.

**Covered Activity** means any recurring activity that is shown in the *Schedule of Benefits* and:

1. takes place under one of the Conditions of Coverage specified in the *Schedule of Benefits*; and
2. is sponsored; organized; scheduled; or otherwise provided by the Policyholder.

**Covered Expenses** means the lesser of the usual and customary charge and the maximum benefit shown, for services or supplies listed, in the *Schedule of Benefits* and described in the *Accident Medical Expense Benefits* section of this Policy. Covered Expenses must be Incurred by a Covered Person for treatment for injuries sustained in a Covered Accident.

**Covered Injury** means any bodily harm that results directly and independently of all other causes from a Covered Accident.

**Covered Loss** means accidental death; dismemberment; or other Injury covered under the Policy.

**Covered Person** means an Eligible Person, as defined in the *Schedule of Benefits*, for whom an enrollment form has been accepted by Us and required premium has been paid when due and for whom coverage under this Policy remains in force.

**Deductible** means the amount of Covered Expenses that each Covered Person must incur as an out of pocket expense during the Policy Year on a per Covered Accident basis before benefits are paid under this Policy. Non-covered expenses do not apply towards the Deductible.

**He, Him or His** means an individual, male or female.

**Health Care Plan** means any arrangement, whether individually purchased or incidental to employment or membership in an association or other group, which provides benefits or services for: health care; dental care; disability benefits; or repatriation of remains. A Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;
4. coverage provided through: Health Maintenance Organizations; Preferred Provider Organizations; State or Federal Exchanges; Insurance Cooperatives and other prepayment; group practice and individual practice plans;
5. medical benefits provided under automobile "fault" and no-fault" – type contracts;
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
  - a. a state-sponsored Medicaid plan; or
  - b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

**Hospital** means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic facility or unit of a Hospital for:

1. rehabilitation; convalescent; custodial; or educational or nursing care;
2. the aged, drug addicts or alcoholics; or
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

**Hospital Stay** means a confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless: (a) separated by at least 90 days; or (b) a Covered Person returns to Active Service for 30 or more days between Hospital Stays.

**Maximum Benefit** means the most we will pay for each Benefit stated in the Schedule of Benefits.

**Nurse** means a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household; or
4. a person employed or retained by the Policyholder.

**Physician** means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the Policyholder; or
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Any services which would be covered if performed by a Physician will be covered if performed by a psychologist, optometrist, social worker, or chiropractor.

**Usual and Customary Charge** means the normal charge, in the absence of insurance, made by the provider of any treatment, but not more than the prevailing charge in the area:

1. for a like service by a provider with similar training or experience; or
2. for a supply that is identical or substantially equivalent.

The final determination of all Usual and Customary Charges rests solely with Us.



## ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

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### Policy Effective Date

We agree to provide Blanket Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page.

### Eligibility

An individual becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

### Effective Date for Individuals

Insurance becomes effective for an Eligible Person on the latest of the following dates:

1. the effective date of this Policy;
2. the date the individual becomes eligible.

### Termination of Insurance

The insurance on a Covered Person will end on the earliest date below:

1. the date the person is no longer in an Eligible Class;
2. the end of the last period for which premium is paid;
3. the date this Policy terminates.

Termination will not affect a claim for a Covered Loss resulting from a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit or Maximum, as shown in the *Schedule of Benefits*, have been paid;
3. the date benefits paid equal any applicable Policy Aggregate Maximum, as shown in the *Schedule of Benefits*.

## CONDITIONS OF COVERAGE

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**This section describes the Conditions of Coverage under which benefits provided by the Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the Common Exclusions sections in order to understand all of the terms, conditions and limitations of coverage.**

### SCHOOL COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, when a Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while he is participating in or attending one of the following School Covered Activities:

1. regularly-scheduled classroom instruction;
2. regularly-scheduled and supervised recess or lunch period;
3. a study period or special instruction period supervised by a member of the school's faculty;
4. a Supervised and Sponsored School Activity;
5. a School authorized internship that includes adult supervision; or
6. Covered School Travel.

Covered School Travel includes travel within the United States, Canada and Mexico only directly and without interruption:

1. between home and school;
2. between home and another meeting place designated by the school;
3. home and another school or site designated by the School, where a Supervised and Sponsored School Activity is scheduled;
4. between the school or other meeting place designated by the school, and another school or site designated by the school, where a Supervised and Sponsored School Activity is scheduled.

### **School Travel coverage for Overnight Supervised and Sponsored School Activities**

Covered School travel also includes travel by any common carrier providing transportation to a Supervised and Sponsored School Activity, within the United States, Canada and Mexico when a Covered Person's participation in or attendance at it requires him to be away from his normal residence for a stay of one or more nights. Coverage for travel to any Covered Activity that takes place outside the United States, Canada and Mexico will be covered only if We have agreed to it in writing.

**Definitions** For purposes of this coverage:

**Supervised and Sponsored School Activity** means a Covered Activity that:

1. takes place:
  - a. on school premises during, before or after normal school hours; or
  - b. at another school or site at which the Covered Activity is scheduled;
2. is sponsored; organized; or otherwise provided, to at which student attendance is required, by the school; and
3. is supervised by a member of the faculty or staff of the school, or by another adult specifically assigned supervisory duties and authority for that Covered Activity by the school, or
4. is a regularly-scheduled sports tryout, practice, workout or training session, team meeting, game, exhibition play or competition in which a Covered Person is participating.

### **Exclusions**

1. This coverage will not be in effect during travel to or from any Supervised and Sponsored School Activity if:
  - a. the school provides transportation to and from it for a group of two or more Covered Persons; and
  - b. a Covered Person is traveling to or from the Supervised and Sponsored School Activity by another means of transportation.
2. This coverage will not be in effect during a Covered Person's Personal Deviation unless specifically provided for in the Schedule of Benefits.
3. This coverage will not be in effect during travel to any Covered Activity that takes place outside the United States, Canada and Mexico unless We have agreed in advance to provide it.

### **VOLUNTARY 24 HOUR COVERAGE**

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss or Incurs Covered Expenses as a direct result, independently of all other causes, of a Covered Accident that occurs any time while insured under this Policy.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.

## COMMON EXCLUSIONS

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In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as: a fare-paying passenger on a regularly scheduled commercial or charter airline;
7. travel in or on any off-road motorized vehicle except a golf cart or any other vehicle We specifically agree to cover not requiring licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. sickness; disease; bodily or mental infirmity; bacterial or viral infection or medical or surgical treatment thereof; except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
11. medical or surgical treatment; diagnostic procedure; administration of anesthesia due to medical mishap or negligence; including malpractice;
12. travel or activity outside the United States, Canada or Mexico;
13. travel in any Aircraft owned, leased or controlled by the Policyholder or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder, if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
14. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
15. voluntary ingestion of any: narcotic; drug; poison; gas; or fumes; unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
16. injuries compensable under Workers' Compensation law or any similar law;
17. occupational injuries for which benefits are not paid under the Workers' Compensation Law or any similar law;
18. a Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;

We will not pay benefits for:

19. services or treatment rendered by a Physician, Nurse or any other person who is:
  - a. employed or retained by the Policyholder;
  - b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
  - c. living in the Covered Person's household;
  - d. who is a parent; sibling; spouse; or child of the Covered Person;
20. any Hospital Stay or days of a Hospital Stay that are not appropriate for the condition and locality.
21. a Covered Person's Covered Loss if:
  - a. he was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and
  - b. he was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

## ACCIDENT MEDICAL EXPENSE BENEFITS

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We will pay benefits shown in the *Schedule of Benefits* for Covered Expenses Incurred by a Covered Person, subject to all applicable conditions and exclusions, for treatment of an injury that resulted directly and independently of all other causes from a Covered Accident.

Benefits will be paid:

1. when Covered Expenses Incurred exceed any applicable Deductible within the number of days from the date of the Covered Accident specified in the *Schedule of Benefits*; and
2. as long as the first expense has been Incurred within the number of days specified in the *Schedule of Benefits*; and
3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired; and
4. until the total of Covered Expenses paid equals any applicable Benefit Limit or maximum Benefit shown in the *Schedule of Benefits*; and
5. until benefits paid equal the Maximum for Accident Medical Expense Benefits shown in The *Schedule of Benefits*.

Expenses for telemedicine will be covered if the health care service would be covered were it provided through in-person consultation between the Covered Person and a health care provider.

### Covered Expenses

#### Inpatient Hospital Services

Room and Board Expenses – We will pay for

1. confinement in an intensive or coronary care unit, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of such confinement; and
2. any other confinement, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of the Hospital Stay.

Miscellaneous Expenses – We will pay the Miscellaneous Expenses charged by a Hospital or ambulatory surgical center for outpatient surgery. Miscellaneous Expenses include, but are not limited to: X-ray; laboratory ; in-Hospital physiotherapy; nurse services; orthopedic appliances; pre-admission tests; and all necessary charges other than room and board, for services received during a Hospital Stay.

#### Ambulatory Medical Center

We will pay Covered Expenses Incurred for medical or surgical treatment provided in a licensed facility that provides ambulatory surgical or medical treatment and is not a Hospital or Physician's office.

#### Emergency Room Treatment

We will pay Covered Expenses Incurred for outpatient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the *Schedule of Benefits*. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Covered Expense.

**Physician Services** – We will pay Covered Expenses for Covered Expenses listed below.

Surgery

1. Covered Expenses charged for performing a surgical procedure. We will pay up to 100% of the Maximum Benefit for a surgical procedure shown in the Schedule of Benefits; and

2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a surgical procedure
3. Covered Expenses charged for treatment of fractured and dislocated bones; operations that involve cutting, incision and/or suturing of wounds; or any other surgical procedure, including aftercare, which is given in the outpatient department of a Hospital or an ambulatory surgical center
4. Any braces, splints or other devices required after surgery to ensure proper healing

Use of Physician's Surgical Facilities – Covered Expenses charged for the use of a Physician's surgical facilities.

Second Opinion or Consultation – Covered Expenses charged by a Physician for a second surgical opinion or consultation.

Physician's Assistant – Covered Expenses charged by a Physician's Assistant for other than pre-or post-operative care, second opinion or consultation:

1. for in-Hospital visits; and
2. for office visits.

Anesthesia and its administration – Covered Expenses charged by a Physician for anesthesia and its administration.

In-Hospital or Office Visits – Covered Expenses charged by a Physician for other than pre-or post-operative care, second opinion or consultation;

1. for in-Hospital visits; and
2. for office visits.

#### **Outpatient X-ray, CT Scan, MRI and Laboratory tests**

We will pay Covered Expenses Incurred, when prescribed by a licensed Physician, for X-ray except dental X-rays; CT Scans; MRI's; and laboratory tests.

#### **Outpatient Physiotherapy**

We will pay Covered Expenses Incurred for outpatient physiotherapy, when prescribed by a licensed Physician, which includes: (a) acupuncture; (b) microthermy; (c) chiropractic adjustment; (d) manipulation; (e) diathermy; (f) massage therapy; (g) heat treatment; and (h) ultrasound treatment.

#### **Nursing Services**

We will pay Covered Expenses Incurred for services other than routine Hospital care, rendered by a Nurse.

#### **Ambulance Services**

We will pay Covered Expenses Incurred for ground or air ambulance service to transport a Covered Person from the place where a Covered Accident occurred to the nearest medically appropriate facility. We will pay Covered Expenses Incurred for ground or air ambulance transportation from the nearest medical facility to another appropriate medical facility if a Physician specifies in writing that specialized care not available in the first facility to which the Covered Person was transported is necessary to treat his injury.

### **Medical Equipment Rental**

We will pay Covered Expenses Incurred for rental or, if less, for purchase of:

1. a wheelchair or hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Covered Person and that can only be used by him. Permanent or therapeutic value is determined solely by Us. Examples of items that are not covered include but are not limited to: computers; motor vehicles and modifications thereof; and ramps and installation costs.

### **Medical Services and Supplies**

We will pay Covered Expenses Incurred for:

1. blood and blood transfusions, including processing and administration; and
2. cost and administration of oxygen and other gasses.

We will not pay for storage of blood for any reason.

### **Dental Services**

We will pay Covered Expense Incurred for dental treatment, including X-rays, for injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered Expenses include: examinations; X-rays; restorative treatment; endodontics; oral surgery; initial braces required for treatment of an injury; and treatment of gingivitis resulting from trauma.

We will pay for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the Policy and when they are within the lawful scope of practice of the independent practice dental hygienist.

Covered Expenses must be Incurred within the Benefit Period shown in the *Schedule of Benefits*. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

### **Prescription Drugs**

We will pay Covered Expenses Incurred for drugs, including amino acid-based elemental infant formula, that

1. can only be obtained through a Physician's written prescription; and
2. are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay Covered Expenses Incurred for drugs that meet (a) above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA. The Covered Expense for a prescription drug is limited to the cost of a generic drug unless substitution of a generic drug is prohibited by law, no generic drug is available, or the Covered Person's Physician specifically request that a non-generic drug be dispensed.



### **Home Health Care**

We will pay Covered Expenses Incurred for care and treatment rendered to a Covered Person by a Home Health Care Agency, for the maximum number of Visits as shown in the *Schedule of Benefits* for:

1. part-time nursing care provided or supervised by a registered graduate nurse;
2. part-time Home Health Aide service which consists of caring for the patient and performing light household tasks as required by the plan of care;
3. physical, speech, occupational, and inhalation therapies when indicated in conjunction with the Covered Person's discharge placement through a rehabilitation facility approved by his Physician and by Us;
4. nutritional counseling; and
5. any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a Physician, but only to the extent that such charges would have been covered under the Policy if the Covered Person had remained in the hospital.

### **Treatment of Alcoholism**

We will pay Covered Expenses Incurred for the treatment of alcoholism when prescribed by a licensed Physician.

### **Excluded Expenses**

None of the following will be considered Covered Expenses unless coverage is specifically provided.

1. Blood, blood plasma or blood storage except expenses by a Hospital for processing or administration of blood.
2. Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
  - a. cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
  - b. reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine: treatment; surgery; health treatment; or examinations; including any service, treatment or supplies that are (a) deemed by Us to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States.
4. Treatment in any Veterans' Administration, Federal or state facility unless there is a legal obligation to pay.
5. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
6. Rest cures or custodial care.
7. Repair or replacement of: existing dentures; partial dentures; braces; or bridgework.
8. Personal services such as television and telephone, or transportation.
9. Expenses payable by any automobile insurance policy without regard to fault.
10. Services or treatment provided by an infirmary operated by the Policyholder.
11. Treatment or service provided by a private duty nurse.

Other Exclusions that apply to this Benefit are in the *Common Exclusions* Section.

## ACCIDENT INDEMNITY BENEFITS

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This Section describes the Accident Indemnity Benefits provided by this Policy. Benefit amounts and any applicable time requirements and limitations are shown in the *Schedule of Benefits*. Please read this and the *Common Exclusions* section in order to understand all of the terms, conditions and limitations applicable to these benefits.

### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

#### Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable.

If a Covered Accident causes the Covered Person's death, the total of all Benefits We will pay for Accidental Death and any other Covered Losses will not exceed the largest Benefit payable for a Covered Loss.

#### Definitions

**Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

**Loss of Sight** means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

**Loss of Speech** means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

**Loss of Hearing** means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

**Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand** means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

**Paralysis or Paralyzed** means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

**Quadriplegia** means total Paralysis of both upper and both lower limbs.

**Paraplegia** means total Paralysis of both lower limbs or both upper limbs.

**Hemiplegia** means total Paralysis of the upper and lower limbs on one side of the body.

**Severance** means the complete and permanent separation and dismemberment of the part from the body.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.



A Member of the Tokio Marine Group

## Philadelphia Indemnity Insurance Company

Administrative Office  
One Bala Plaza, Suite 100, Bala Cynwyd, PA 19004  
Tel: 800-873-4552

### EXPANDED MEDICAL BENEFIT ENDORSEMENT

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This Endorsement is attached to and made part of this Policy. It is subject to all of the Policy provisions that do not conflict with its provisions.

Policyholder: Bowdoin College  
Policy Number: PHPA139537  
Endorsement Effective Date: 8/1/2023

We will pay Covered Expenses Incurred for treatment of existing Sports Conditions shown in the *Schedule of Benefits* if they are aggravated by the Covered Person's participation in a Covered Activity, but only if his Physician has released him to participate in the Covered Activity during which the re-aggravation occurred.

All other terms, conditions and limitations of the Blanket Accident Insurance Policy apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Blanket Accident Insurance Policy, this Endorsement will control.

This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless signed by our authorized representative.

President & CEO  
Philadelphia Indemnity Insurance Company

Secretary  
Philadelphia Indemnity Insurance Company



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### HEART AND CIRCULATORY CONDITIONS ENDORSEMENT

This Endorsement is attached to and made part of the Policy. It is subject to all of the Policy provisions that do not conflict with its provisions.

Policyholder	Bowdoin College
Policy Number	PHPA139537
Endorsement Effective Date	8/1/2023

We will pay Covered Expenses Incurred for the treatment of heart and circulatory conditions shown in the *Schedule of Benefits* if:

1. they occur and are manifested during or within 24 hours of a Covered Activity; and
2. the Covered Person has neither received nor been advised to have any medical treatment for the condition.

We will pay the Principal Sum if the Covered Person dies as a result of a heart and circulatory condition that meets all the requirements described below, within 90 days of taking part in a Covered Activity:

1. they occur and are manifested during or within 24 hours of a Covered Activity; and
2. the Covered Person has neither received nor been advised to have any medical treatment for the condition.

All other terms, conditions and limitations of the Blanket Accident Insurance Policy apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Blanket Accident Insurance Policy, this Endorsement will control.

This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless signed by our authorized representative.

President & CEO  
Philadelphia Indemnity Insurance Company

Secretary  
Philadelphia Indemnity Insurance Company



**PHILADELPHIA**  
INSURANCE COMPANIES

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### HMO/PPO DENIAL BENEFIT ENDORSEMENT

This Endorsement is attached to and made part of the Policy. It is subject to all of the Policy provisions that do not conflict with its provisions.

Policyholder	Bowdoin College
Policy Number	PHPA139537
Endorsement Effective Date	8/1/2023

We will pay Covered Expenses Incurred, up to the maximum shown in the *Schedule of Benefits*, when benefits are denied or reduced by an HMO or PPO plan because services provided to treat an Injury were: 1) rendered by an Non-Preferred Provider; or 2) received outside of the network's service area.

If benefits are reduced rather than denied by an HMO or PPO for the reasons described above, We will pay an amount equal to the Covered Expense Incurred less the amount paid by the HMO or PPO. The Other Health Plan Reduction, shown on the *Schedule of Benefits* under the Scope of Coverage Applicable to Accident Medical Benefits, is amended to read "not applicable".

**Exclusions** Exclusions that apply to this coverage in the *Common Exclusions* Section.

All other terms, conditions and limitations of the Blanket Accident Insurance Policy apply to this Endorsement. In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Blanket Accident Insurance Policy, this Endorsement will control. This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless signed by our authorized representative.

President & CEO  
Philadelphia Indemnity Insurance Company

Secretary  
Philadelphia Indemnity Insurance Company