2024 - 2025 VOLUNTARY STUDENT ACCIDENT INSURANCE

PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

Underwritten by:
Philadelphia Indemnity Insurance Company (PIIC)
Rated "A++" (Superior) by AM Best Company

800.734.9326 | **PHLY.com**

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Who is Eligible?
An individual who is a student or employee of the Policyholder.

Who Pays the Premium?
The cost of this insurance is paid by Covered Persons.

Effective Date for Individuals and Termination of Insurance.
Insurance becomes effective for an Eligible Person who enrolls and agrees to make required contributions on the latest of the following dates:

1. The effective date of this Policy;
2. The date the individual becomes eligible;
3. The date We receive the Eligible Person's completed enrollment form and the required first premium.

The Insurance 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.

Choice of Two Options that automatically include Extended Dental benefits.

Option 1: School Coverage Excluding Participation in Interscholastic Sports

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 School authorized internship that includes adult supervision;
5. Covered School Travel within the United States, Canada, and Mexico between
    1. Home and school;
    2. Between home and another meeting place designated by the school.

Option 2: 24-Hour Coverage Excluding Participation in Interscholastic Sports

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.

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Accident Insurance Protection
Providing a maximum Accident Medical Expense Benefit of $25,000

Primary Medical Expenses
We will pay Covered Expenses without regard to any Health Care Plan the Covered Person may have, after any applicable Deductible has been satisfied.

Covered Expenses
Means the lesser of the reasonable 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.

Usual and Customary (U&C)
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.

Primary Coverage - pays regardless of other health insurance
Provides for payment of Usual and Customary (U&C) expenses incurred for treatment of an injury caused by a Covered Accident, subject to the maximum stated in the policy and a $100.00 deductible. Covered Expenses must be for medically necessary treatment, and the first expense must be incurred within 90 days following the Covered Accident. To be payable, expenses must be incurred within 365 days after the Covered Accident. All benefits will be based on the normal charge, in the absence of insurance, made by the provider for any medically necessary treatment, but not more than the prevailing charge in the area for like services by a provider with similar training and experience.

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
One of the following will be *included*. - Primary Medical Expense

Medical Expense Benefits:
Total Maximum for all
Accident Medical Expense Benefits..... $25,000

First Covered Expenses must
be Incurred within..... 180 days after a
..... Covered Accident
Benefit Period..... 365 days from the date of
..... the Covered Accident
Deductible $100
does not..... include Covered Expenses
..... paid under another
..... Health Care Plan

Covered Expenses:
Mobile Field Hospital..... 80%

In-Patient Hospital Services
Daily ICU or CCU Benefit..... 80%

Daily In-Hospital Benefit
of the average Semi-private room rate 80%

Miscellaneous Services..... 80% per Hospital Stay

Ambulatory Medical Center..... 80%

Emergency Room Treatment 80%

Physician Services
Surgery Benefit..... 80%
Assistant Surgeon..... 80%
Physician's Surgical Facilities..... 80%

Always include when surgical services are included
Second Opinion or Consultation 80%
Physician's Assistant..... 80%
Anesthesia Benefit 80%

Inpatient Visits..... 80%
Office Visits..... 80% per visit

Outpatient X-ray, CT Scan,
MRI and Laboratory Test 80%

Outpatient Physiotherapy 80%

Nursing Services..... 80%

Ambulance Services.....Benefit will be based on the rate published by the Connecticut Department of Public Health

Medical Equipment Rental..... 80%

Medical Services and Supplies.....80%

Dental Services..... 80%

Prescription Drug Benefit
Benefit per prescription 80%

Home Health Care Benefit
Calendar Year Deductible..... $0

Home Health Care Visit.....
the lesser of (1) 75% of usual and customary charge, or (2) billed charges

Maximum Visits.....80 per calendar year or in any continuous period of 12 months.

*This maximum does not apply to a Covered Person diagnosed by a physician as terminally ill with a prognosis of six months or less to live. In this case the yearly benefit for medical social services shall not exceed..... $200.

Medical Supplies, Drugs and Medications..... 100%

Each visit by a representative of a home health agency shall be considered as one visit; four hours of home health aide service shall be considered as one visit.

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Accidental Death, Dismemberment Benefits

Principal Sum $25,000
Loss must occur within ..... 365 days of 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	200% of the Principal Sum
Loss of Sight of Both Eyes	200% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	200% of the Principal Sum
Loss of One Hand or Foot	100% of the Principal Sum
Loss of Sight in One Eye	100% of the Principal Sum
Loss of Speech	100% of the Principal Sum
Loss of Hearing in Both Ears	100% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	50% of the Principal Sum

Aggregate Limit of Indemnity $500,000
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.

Extended Dental Expense Benefit

Benefit Period..... 2 years
Benefit Maximum..... $50,000 per Covered Accident
Benefit Percentage..... 100%

We will pay Extended Dental Expense Benefits, up to the Extended Dental Benefit Maximum shown above, for Covered Dental Expenses Incurred by a Covered Person, subject to all applicable conditions and exclusions, for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident.

Covered Dental Expenses

Extended Dental Expenses must be Incurred within the Extended Dental Benefit Period shown in the Schedule of Benefits.

Covered Dental Expenses include expenses Incurred for the treatment repair and replacement of each injured, natural tooth, including: examination; diagnosis; x-ray; restorative treatment; endodontics; and oral surgery; plus the replacement of caps; crowns; dentures; and orthopedic appliances. 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.

Exclusions that apply to this benefit are specified in the Common Exclusions Section.

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

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to Us within 90 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Notice can be given: to Us at Our Administrative Office, One Bala Plaza, Suite 100, Bala Cynwyd, PA 19004; or to such other place as We may designate for the purpose; or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name and address.

Claim Forms

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Questions regarding claim filing procedures or claim status can be directed to: claims@nahga.com or 800-952-4320.

Questions regarding this plan? Contact us:

Philadelphia Insurance Companies
800.734.9326
E-mail: AH@phly.com

Ask for our K12 Student Accident Department

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss that, 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 of a felony for which the Covered Person has been convicted under State of Federal law.
3. Voluntary commission of or voluntary 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 airline;
7. Travel in or on any off-road motorized vehicle 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. Travel or activity outside the United States, Canada, or Mexico;
12. 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;
13. The Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;

We will not pay benefits for:

14. 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;
15. Any hospital stay or days of a hospital stay that are not appropriate for the condition and locality.
16. 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.

EXCLUDED EXPENSES

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 of injuries that result over a period of time, such as blisters, tennis elbow, et al, that are a normal, foreseeable result of participation in the Covered Activity.
12. Treatment or service provided by a private duty nurse.
13. Treatment of hernia of any kind.

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

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Print Application Clear Application

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2024 - 2025 Enrollment Form

School Name _____

School District Name _____ Grade/Dept _____

Person to be Insured _____

Address _____

City, _____ State, _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____

Parent Signature _____

Student accident insurance chosen for: ☐ Student ☐ Faculty ☐ Admin

Coverage Chosen: (Select only one) **Annual Premium**

School Time with Extended Dental ☐ $12.00

24-Hour Coverage with Extended Dental ☐ $74.00

Date: _____ Amount enclosed: _____ (Do not send cash)

Please include check or money order payable to:

Philadelphia Insurance Companies

There is no obligation to purchase this insurance.

After selecting the school-approved insurance plan that's best for you:

- ✓ Complete the enrollment form and print it out
- ✓ Enclose a check or money order
- ✓ Do not send cash
- ✓ Return enrollment form and check or money order to:

Philadelphia Insurance Companies
500 Mamaroneck Ave, Suite 402
Harrison, NY 10528

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AM BEST A++ SUPERIOR Financial Strength Rating