

BENEFITS AT A GLANCE

ACCIDENT AND SICKNESS MEDICAL INDEMNITY PLAN | PLAN YEAR 2025/2026

DESIGNED EXCLUSIVELY FOR THE STUDENTS
OF:

Lewis University
Romeoville, IL
("the Policyholder")

Policy Number: WI2526ILIND10
Group Number: ST1799FI
Effective: 8/1/2025 - 7/31/2026

UNDERWRITTEN BY:

Wellfleet Insurance Company | Fort Wayne, IN
("the Company")

ADMINISTERED BY:

Wellfleet Group, LLC.



WELLFLEET
STUDENT

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Welcome Students...

We are pleased to provide you with this summary of the 2025–2026 Student Accident and Sickness Medical Indemnity Plan (“Plan”). This plan provides limited Accident & Sickness Coverage. It is not a substitute for Comprehensive Health Insurance Coverage and does not qualify as Minimum Essential Health Coverage under the Affordable Care Act. “Benefits at a Glance” includes effective dates and costs of coverage, as well as other helpful information. For additional details about the Plan, please consult the Plan Certificate and other materials at www.wellfleetstudent.com. For questions about medical benefits or claims, please call Wellfleet Student at (877) 657-5030.

Where to Find Help

For Questions About:	Please Contact:
<ul style="list-style-type: none"> • Claims Administrator • Insurance Benefits • Claims Processing • Eligibility • ID Cards 	<p>Wellfleet Group, LLC. PO Box 15369 Springfield, MA 01115-5369 (877) 657-5030 www.wellfleetstudent.com</p>
<p>Local Representative</p> <ul style="list-style-type: none"> • Enrollment • Eligibility 	<p>First Agency, a Gallagher Company 5071 West H Ave. Kalamazoo, MI 49009 (269) 381-6630 www.1stAgency.com</p>

Am I Eligible?

All full-time students carrying 12 credits or more, and part-time students carrying 6 credits or more, attending Lewis University are eligible to enroll in this Plan on a voluntary basis. Students are covered for the period for which premium has been paid. Eligibility requirements must be met each time premium is paid to continue Coverage. Insured Students who enroll in the plan may also enroll their eligible dependents. Dependents must be enrolled for the same period of coverage as the insured student.

How Do I Enroll?

All eligible students can go to www.1stAgency.com to enroll in the Lewis University Accident and Sickness Medical Indemnity Plan. The deadline to enroll in the Annual and Fall Plan is 9/30/2025 and the deadline to enroll for the Spring term is 2/28/2026. Enrollment is allowed throughout the year for students entering Allied Health Programs.

Effective Dates & Costs

Effective Dates and Plan Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

	Annual 8/1/2025 – 7/31/2026	Fall 8/1/2025 – 12/31/2025	Spring 1/1/2026 – 7/31/2026
Student	\$536	\$201	\$335
Spouse	\$633	\$241	\$392
Each Child	\$511	\$195	\$316
3 or more Children	\$1,533	\$585	\$948
The above plan costs include an administrative service fee. Dependent costs are in addition to the student's cost			

DEADLINE TO ENROLL

Annual	Fall	Spring
9/30/2025	9/30/2025	2/28/2026

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum	\$50,000
Loss must occur within	365 days of the covered accident
Accidental Death and Dismemberment Aggregate Limit	\$1,000,000

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands or Both Feet	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of Sight of Both Eyes	Principal Sum
Loss of One Hand or foot and Sight of One Eye	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of Principal Sum
Loss of all Four Fingers of the Same Hand	50% of Principal Sum
Loss of all the Toes of the Same Foot	50% of Principal Sum
Loss of Thumb	25% of Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech and Hearing (in both ears)	Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in one or both ears	50% of the Principal Sum

ACCIDENT AND SICKNESS MEDICAL INDEMNITY BENEFITS

Any benefit limits for *Accident and Sickness Medical Indemnity Benefits* apply, unless otherwise specified, on a per covered accident or sickness basis. A covered injury must result directly and independently of disease, sickness or bodily infirmity from a covered accident occurring while insured under this certificate.

Covered Expenses for which benefits are payable are outlined below.

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT and SICKNESS MEDICAL INDEMNITY BENEFITS**ACCIDENT AND SICKNESS MEDICAL INDEMNITY BENEFITS**

Covered Expenses	Coverage and Other Limits per Policy Term
Inpatient Hospital Services	
Hospital Stay Daily Income Benefit	\$100 per day
Maximum Number of Days per Inpatient hospital stay	90 days
Outpatient Facilities	
Ambulatory Medical or Surgical Center Benefit, including operating room	\$250 per visit
Maximum Number of Visits	1
Outpatient Hospital Surgical Services Benefit	\$250 per visit
Maximum Number of Outpatient Hospital Surgical Services Visits	1
Emergency Room Benefit	\$500 per visit
Maximum Number of Visits	2
Home Health Care Benefit	\$50 per visit
Maximum Number of home health care Visits	3
Rehabilitation Facility Benefit	\$50 per day
Maximum Number of Days	5
Physician Services	
Surgery Benefit	\$500 per surgery
Maximum Number of Surgeries	1
Urgent Care Benefit	\$50 per visit
Maximum Number of Visits	5
Anesthesia and its Administration Benefit	\$100
Maximum Number of Events	1
In-Hospital or Office Visits Benefit	\$75 per visit
Maximum Number of Visits	6
Outpatient X-ray, CT Scan, MRI and Laboratory Tests	
Outpatient X-Rays, CT Scans & MRIs Benefit	\$100
Maximum Number of Procedures	1
Outpatient Laboratory Tests Benefit	\$40 per test
Maximum Number of Tests	2
Outpatient Services and Supplies	
Outpatient Physical Therapy Benefit	\$50 per visit
Maximum Number of physical therapy Visits	5
Outpatient Occupational and Speech Therapy Benefit	\$50 per visit
Maximum Number of Occupational and Speech Therapy visits combined	5
Nursing Services- Private Duty Nursing Benefit	\$50 per visit
Maximum Number of Visits	3
Ambulance Services Benefit	
Ground Ambulance Benefit	\$500 per trip

Air/Water Ambulance Benefit	\$500 per trip
Maximum Number of Trips	2
Durable Medical Equipment and Orthopedic Braces and Appliances Benefit	\$50 per purchase and/or rental
Maximum Number of purchases and/or rentals	2
Other benefits	
Wellness Care Visits Benefit	
Annual Physical	\$75 per visit
Maximum Number of Visits	1
Mammogram Screening	\$50 per visit
Maximum Number of Visits	1
Cervical Cancer Screening	\$25 per visit
Maximum Number of Visits	1

GENERAL EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any **covered injury, sickness, covered loss or covered expense** which is independently caused by or results from any of the following unless coverage is specifically provided for by name in this **certificate**:

1. Any service, treatment or supply that is not considered **medically necessary** as defined in this certificate.
2. Expenses **incurred** after the date insurance terminates as to a **covered person**, except as specified in the extension of benefits provision; and the end of the **policy term**, even if **incurred** for continuing services or treatment of a **covered injury or sickness**.
3. Benefits provided by a Government plan (except Medicaid and other public assistance plans).
4. Injuries compensable under Workers' Compensation law or any similar law.
5. Sojourns or **Personal** deviations are not covered.
6. Declared or undeclared **war** or act of **war**.
7. Commission or attempt to commit a felony or an assault.
8. Commission of or active participation in a riot or insurrection.
9. Aggravation, during a **covered activity**, of an injury the **covered person** suffered before participating in that **covered activity**, unless **we** receive a written medical release from the **covered person's physician**.
10. Practice or play in any sports activity intercollegiate tackle football **intercollegiate sports** semi-professional sports or professional sports, including travel to and from the activity and practice except as specifically listed in the Schedule of Benefits.
11. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface, except as:
 - a. A fare-paying passenger on a regularly scheduled commercial or charter airline.
 - b. A passenger in a non-scheduled, private aircraft used for pleasure purposes with no commercial intent during the flight.
 - c. An ultra-light or glider.
 - d. A passenger in a military aircraft flown by the Air Mobility Command or its foreign equivalent.
12. Travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle.
13. An **accident** if the **covered person** is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) The **covered person** holds a valid learner's permit and (b) The **covered person** is receiving instruction from a Driver's Education Instructor.
14. Travel or activity outside the contiguous United States, Alaska, Hawaii and the territories and possessions of the United States, Canada, or Mexico.
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. An **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.
17. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.

18. Examination or prescriptions for, or purchase, repair, or replacement of, eyeglasses, contact lenses except due to a **covered accident** as described elsewhere in this **certificate**.
19. Hearing examinations or hearing aids, or purchase, repair, or replacement of.
20. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices.
21. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the **covered person** has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the laws of the jurisdiction in which the **covered accident** occurred.
22. Rest cures, long-term care, or custodial care.
23. Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - a. Cosmetic surgery resulting from a **covered accident** if the **covered person's** initial treatment had begun within 90 days of the date of the **covered accident**.
 - b. Reconstruction incidental to or following surgery resulting from a **covered accident** or **sickness**.
24. Any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) Are deemed to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States.
25. Services or treatment provided by persons who do not normally charge for their services unless there is a legal obligation to pay.
26. Repair or replacement of existing dentures, partial dentures, braces, or bridgework.
27. Treatment or services provided by the **covered person's immediate family**.
28. Personal services, or comfort/convenience items such as television and telephone or transportation.
29. Orthopedic appliances used mainly to protect an injury so that the **covered person** can take part in **intramural, interscholastic, club or recreational sports**.
30. Expenses payable by any automobile insurance **policy** without regard to fault.
31. Services or treatment provided by an infirmary operated by the **policyholder**.
32. Treatment or service provided by a private duty **nurse** except due to a **covered accident** as described elsewhere in this **certificate**.
33. Charges for hot or cold packs.
34. Custodial Care service and supplies.
35. Expenses that are not recommended and approved by a **physician**.
36. Repair or replacement of existing artificial limbs, eyes, and larynx, unless damaged or destroyed in a **covered accident**.
37. Participation in any sports activity not specifically authorized, sponsored, and supervised by the **school, policyholder**, whether or not it takes place on **school, policyholder** premises or during normal **school** hours, including but not limited to snowboarding, skateboarding, motorcycle racing, racing rocket-powered, jet propelled or nuclear-powered vehicles (or any other activity to be excluded).
38. Any expenses in excess of **usual and reasonable charges** except as provided in this **certificate**.
39. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
40. Racing or speed contests, skin diving, sky diving, mountaineering (where ropes or guides are customarily used), parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles), or other hazardous sport or hobby.
41. Non-physical, occupational, speech therapies (art, dance, etc.).
42. Modifications made to dwellings.
43. General fitness, exercise programs.
44. Hypnosis.
45. Rolfing.
46. Biofeedback.
47. Acupuncture charges.
48. Chiropractic care or spinal manipulation charges.
49. Care or treatment of allergies, including allergy testing.
50. Diagnosis and care or treatment of acne.