Drury University
Benefit Guide

Thank you for choosing Seven Corners to service your international health insurance needs. Our goal is to provide you with complete, efficient, and helpful service. We have created this Benefit Guide as a quick reference tool for your benefits.

This Benefit Guide is a summary of emergency information and instructions; it is not a substitute for your review of the Certificate of Insurance which has been provided. For a full and detailed explanation of benefits, provisions, and exclusions from which claims are processed and coverage determinations made, please refer to the official Certificate of Insurance. If you do not have a copy of the Certificate of Insurance, please immediately contact Seven Corners for another copy.

Group Number: GLB-9498599-01LS
Coverage Dates: 06/02/2011 – 06/01/2012

Your ID card contains important contact information and *your individual certificate number*, which you will need when you contact us.

Finding a Provider:
U.S. and International PPO information for your plan can be found here:
http://www.sevencorners.com/networkproviders/insuredproducts
(U.S. providers only)
Available by phone from our **Assist Department** 24/7
Inside the United States: 1-800-690-6295;
Outside the United States: 0-317-818-2808 (Collect)
Fax: 1-317-815-5984
E-mail: assist@sevencorners.com
A complete list of international providers is also available at Wellabroad.com

Wellabroad.com: Our real-time, information-rich Web site offers quick and easy access to important and varied travel information free to our insureds. It contains travel advisories and warnings as well as country-specific background information including entry requirements, languages, and airport locations. The site also provides common travel resources such as international area codes, language tools and currency and time zone converters. You will find a complete listing of international providers here as well.

MyPlan: This service area provides information about your eligibility, preferred providers, and claims (including Explanation of Benefit forms). You may also contact us through this area. Instructions for accessing MyPlan are provided on your ID card.

Understanding Your Benefits: Attached you will find a brief Schedule of Benefits with detail on your deductible, coinsurance, and benefits.

Eligibility: Your plan provides coverage for any international student or scholar with a current non-immigrant visa who is enrolled at Drury University. Persons with permanent residency status are not eligible to enroll in this plan. Benefits will be paid for a covered Injury or Sickness for students during brief return visits to their homeland. This will be limited to 90 days of coverage and $25,000 maximum per Policy year. All insured students may purchase Intercollegiate Sports coverage on an optional basis. Please see the attached Schedule of Benefits for details.

Pre-Notification Guidelines: Your complete benefits often require that you give notice to Seven Corners either before or within 48 hours of receiving treatment. You must notify Seven Corners through our Assist department at the contact information shown above by phone, fax, or e-mail.

1. You (or someone on your behalf) must notify Seven Corners 48 hours *before* a scheduled, non-emergency hospital admission anywhere in the world.
2. You (or someone on your behalf) must notify Seven Corners within 48 hours of an emergency hospital admission anywhere in the world.
3. You (or someone on your behalf) must notify Seven Corners 48 hours *before* any Outpatient treatment anywhere in the world.

Failure to pre-notify as stated will result in a reduction of benefits and/or an additional deductible.
Pre-notification does not guarantee payment of benefits.

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Pre-existing Conditions: A pre-existing condition is one that predates the effective date of your coverage and is not covered until you have been on the plan for a complete year. This 12-month waiting period may be reduced if you submit a Certificate of Creditable Coverage. We will review this certificate and determine the length of your waiting period.

Schedule of Benefits

Lifetime Maximum Benefit	$250,000 for Students $50,000 for Dependents
Deductible	$100. The deductible for students will be waived when treatment is rendered at the Student Health Center, referral was provided by the Student Health Center, treatment is provided more than 50 miles from campus, or when Student Health Center is closed.
Coinsurance In Network	After the deductible, the policy pays 100% of eligible expenses to the policy maximum.
Coinsurance Out of Network	After the deductible, the policy pays 80% eligible expenses to the policy maximum.
Hospital Room and Board Expense	When Your Injury or Sickness requires Hospital confinement, We will pay the Hospital room and board Expense up to the semi-private rate. Benefit also applies to Intensive Care Unit. Subject to deductible and coinsurance.
Hospital Miscellaneous Expense	We will pay the Expenses incurred by You during a Hospital confinement or as an outpatient for day surgery for services provided by a Hospital, ambulatory surgical center or ambulatory medical center. We will pay for anesthesia, operating room, laboratory tests, x-rays, oxygen, drugs, medicines, dressings, and other necessary non-room and board Expenses. Subject to deductible and coinsurance.
Surgical Expense	When Your Injury or Sickness requires surgery, We will pay the Expense based on the MDR (Medical Data Research) survey of surgical fees valued at the 90th percentile. Only one surgical procedure will be covered when multiple procedures are performed unless Medically necessary. Subject to deductible and coinsurance.
Anesthetist	If the surgery requires the services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed, We will pay the Expense. Subject to deductible and coinsurance.
In-Hospital Physician Fee Expense	If, while confined to a Hospital, Your Injury or Sickness requires the services of a Physician, We will pay the Expense for such services. Subject to deductible and coinsurance.
Outpatient Physician	When Your Injury or Sickness requires the services of a Physician, while not confined to a Hospital, We will pay the Expense. Subject to deductible and coinsurance.
Physical Therapy Expense	When Your Injury or Sickness requires Physical Therapy, including, but not limited to diagnosis, evaluation, diagnostic, x-ray/lab, and therapeutic modalities, We will pay the expense up to 5 visits. Subject to deductible and coinsurance.
Consultant or Specialist Expense	When Your Injury or Sickness requires the services of a consultant or specialist, as requested by the attending Physician, We will pay the Expense. Subject to deductible and coinsurance.
Licensed Nurse Expense	If, while confined in a Hospital, Your Injury or Sickness requires the services of an R.N. or licensed practical nurse, We will pay the Expense. Subject to deductible and coinsurance.
Ambulance Expense	When Your Injury or Sickness requires the use of an ambulance or air ambulance, We will pay the Expense. Subject to deductible and coinsurance.
Diagnostic X-ray & Laboratory Expense	When Your Injury or Sickness requires diagnostic x-ray, including ultrasound, MRI, and CAT Scan, or laboratory services, under the Physicians direction, We will pay the Expense. Subject to deductible and coinsurance.
Hospital Outpatient Expense	When Your Injury or Sickness requires the use of outpatient facilities of an emergency room, under the Physician's direction, We will pay the Expense. Subject to deductible and coinsurance.
Prescribed Medicines Expense	When Your Injury or Sickness requires prescribed medicines, including contraceptives, We will pay the Expense. Subject to deductible and coinsurance.
Preadmission Testing	When Your Injury or Sickness requires Preadmission Testing, We will pay the Expense. Subject to deductible and coinsurance.
Emergency Medical	When Your Injury or Sickness requires Emergency Medical care, We will pay the Expense. Subject to deductible and coinsurance.
2nd Surgical Opinion	When Your Injury or Sickness requires a 2nd Surgical Opinion, We will pay the Expense. Subject to deductible and coinsurance.
Durable Medical	When your Injury or Sickness requires the use of durable medical equipment or supplies, We will pay for the rental charge or the purchase of new equipment, whichever is less. Subject to deductible and coinsurance.
STD Testing	When Your Sickness requires STD testing, We will pay the expense. Subject to deductible and coinsurance.
Outpatient Mental Illness Expense	We will pay the Expense for recognized mental illness while not Hospital confined, including treatment through partial or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other Sickness. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Outpatient Chemical Dependency Expense	When You require treatment for chemical dependency, We will pay the Expense for the following: outpatient treatment through a nonresidential treatment program, or through partial or full-day program services, of not less than 26 days per benefit period. The coverages set forth above shall be subject to a separate lifetime frequency cap of not less than ten episodes of treatment. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Inpatient Chemical Dependency Expense	When You require inpatient treatment for chemical dependency, We will pay the Expense for the following: 1)a residential program of not less than 21 days per benefit period 2) medical or social setting detoxification of not less than six days per benefit period. The coverages set forth above shall be subject to a separate lifetime frequency cap of not less than ten episodes of treatment. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.

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Inpatient Mental Illness Expense:	We will pay the Expense for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the Department of Mental Health or accredited by the Joint Commission on Accreditation of Hospitals. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Enteral Formulas and Inborn Errors of Metabolism Expense	We will pay the Expense for prescription and non-prescription enteral formulas for home use which are Physician prescribed as Medically Necessary for the treatment of inherited diseases for amino acid, organic acid, carbohydrate, or fat metabolism as well as mal-absorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids, and organic acids shall include food products modified to be low protein, in an amount not to exceed $3,000 annually for an Insured, through the age of 24. The coverage applies to any Insured notwithstanding the existence of any Pre-Existing Condition. Subject to deductible and coinsurance.
Mammography Expense	We will pay the Expense for low-dose mammography screening for any non-symptomatic woman covered under the policy subject to the following: a) a baseline mammogram for women age 35 to 39; b) a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the recommendation of the patient's Physician; c) a mammogram every year for women age 50 and over; and d) a mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer. Subject to deductible and coinsurance.
Speech and Hearing Disorder Expense	We will pay the Expense for the necessary care and treatment of loss or impairment of speech or hearing subject to the same policy period, maximums, Deductibles and coinsurance factors as other covered services. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Breast Cancer Expense	We will pay the Expense for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/ autologous bone marrow transplants or stem cell transplants. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Child Health Supervision Services Expense	We will pay the Expense for child health supervision services to include benefits from the moment of birth through the age of 12 years. Child health supervision services shall only be covered to the extent that services are provided by or under the supervision of a single Physician during the course of one visit. We shall provide benefits at the following age intervals: birth, two months, four months, six months, nine months, 12 months, 18 months, two years, three years, four years, five years, six years, eight years, ten years and 12 years. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Maternity Benefits Expense	We will pay the Expense for: a) a minimum of 48 hours of inpatient care following a vaginal delivery; b) a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child in a Hospital or any health care facility licensed to provide obstetrical care; c) a shorter length of Hospital stay for services related to maternity and newborn care if a shorter stay meets with the approval of the attending Physician after consulting with the mother; and d) post discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a Physician. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.
Diabetes Services Expense	We will pay the Expense for all Physician prescribed medically appropriate and necessary equipment, supplies and self-management training in the management and treatment of diabetes for persons with gestational, Type I or Type II diabetes. Subject to deductible and coinsurance.
PKU Formula Expense	We will pay the Expense for formula recommended by a Physician for the treatment of a patient with phenylketonuria or any inherited disease of amino or organic acids. "PKU/Phenylketonuria" means a congenital disease of newborns due to inability to metabolize the substance phenylalanine. Subject to deductible and coinsurance.
Reconstructive Breast Surgery Expense	We will pay the Expenses for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast and prosthetic devices, including devices to restore and achieve symmetry for the patient incident to the mastectomy. Subject to deductible and coinsurance.
Prostate Cancer Screening Expense	We will pay the Expense for conducting a medically recognized diagnostic examination, which shall include a digital rectal exam, and a blood test called the prostate-specific antigen (PSA) test: a) for men who are between 40 and 75 years of age; b) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; c) when used for staging in determining the need for a bone scan in patients with prostate cancer; d) when used for male patients who are at high risk for prostate cancer; and e) any nonsymptomatic man covered by the policy in accordance with the current American Cancer Society guidelines. Subject to deductible and coinsurance.
Colorectal Exams Expense	We will pay the Expense incurred in conducting a medically recognized colorectal exam for any nonsymptomatic man covered by the policy in accordance with the current American Cancer Society guidelines. Pelvic Exam and Pap Smear Expense: We will pay the Expense for a pelvic examination and pap smear examination including FDA approved cytological screening technology. Subject to deductible and coinsurance.
Pelvic Exam and Pap Smear Expense	We will pay the Expense for a pelvic examination and pap smear examination including FDA approved cytological screening technology. Subject to deductible and coinsurance.
General Anesthesia For Hospital Dental Procedures Expense	When Your Sickness requires treatment for dental Expense, We will pay as follows: a) the Expense up to the hospitalized maximum if confined to a Hospital; b) the Expense up to the outpatient maximum if not confined to a Hospital; c) coverage for the administration of general anesthesia and Hospital charges for dental care provided to a child under the age of five, a person who is severely disabled, or a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided; and d) coverage for administration of general anesthesia, Hospital or office charges for treatment required by a dentist, regardless of whether the services are provided in a participating Hospital or surgical center or office. Subject to deductible and coinsurance.

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Clinical Trials Expense	We will pay the Expense incurred in connection with a phase II, III or IV clinical trial as long as the treating facility and personnel have the expertise and training to provide the treatment. We will cover routine patient costs incurred for drugs and devices approved by the Food and Drug Administration; and reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Subject to deductible and coinsurance.
Emergency Evacuation Benefit	We will pay for Covered Emergency Evacuation Expenses incurred if the Insured person suffers an Injury or Sickness that requires Emergency Evacuation while on Covered Travel. Benefits payable are subject to a maximum amount per Insured person of $50,000 for all Emergency Evacuations due to all Injuries from the same Accident or all Sicknesses from the same or related causes. The Medical Professional must order the Emergency Evacuation and must certify that the severity of the Insured person's Injury or emergency Sickness warrants his or her Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible. Subject to deductible and coinsurance.
Medically Necessary Transportation	If the Insured person is hospitalized for more than five consecutive days following a Covered Emergency Evacuation, We will pay, subject to any limitations stated herein, for Expenses to return the Insured person from the medical facility to which he or she was treated to the Insured person's return destination, less refunds from the Insured person's unused Transportation tickets. Airfare costs will be economy or first class if the Insured person's original tickets are first class. Subject to deductible and coinsurance.
Family Visitation Expense	If the Insured person is unable to travel due to a Covered Emergency Evacuation, We will pay, subject to any limitations stated herein, for Expenses to bring a family member to and from the Hospital or other medical facility where the Insured person is confined, not to exceed the cost of one round-trip economy airfare ticket. The aggregate maximum payable for this benefit is $1,000. Subject to deductible and coinsurance.
Repatriation of Remains Benefit	If the Insured person suffers a covered loss of life while on Covered Travel, We will pay, subject to the limitations stated below, for Covered Expenses reasonably incurred to return the Insured person's body to their home country, but not exceeding a maximum per Insured person benefit amount of $50,000. Covered Expenses include, but are not limited to, Expenses incurred in accordance with the applicable international requirements for: (1) embalming; (2) cremation; (3) the most economical coffins or receptacles adequate for Transportation of the remains; and (4) Transportation, according to airline tariffs, of the remains by the most direct and economical conveyance and route possible. Benefits will not be provided for any Expense provided by another party at no cost to the Insured person or already included in the cost of the Covered Travel. We or Our representative must authorize all Expenses in advance for any travel benefit to be payable. Subject to deductible and coinsurance.
Intercollegiate Sports (if applicable premium has been paid)	Provided that the additional premium has been paid and subject to a Deductible of $100, benefits will be paid for 100% of Preferred Allowance and 100% of Usual and Customary Charges incurred for intercollegiate sports Injury up to $90,000 Per Policy Year. Insured student athletes who are members of and are participating in intercollegiate Baseball, Softball, Basketball, Volleyball, Soccer, Cheerleading, Golf, Tennis, Swimming, and Cross Country sponsored by the Policyholder are covered for sports Injury as follows. Coverage extends to completion, practice, training (i.e.: weight room) and travel to and from. No benefits will be paid for: 1. Infections, except pyogenic infections caused by an accidental bodily Injury, or infections resulting from the accidental ingestion of contaminated substances; 2. Cysts, blisters, or boils; 3. Overexertion; heat exhaustion; fainting; 4. Hernia, regardless of how caused; and 5. Injury to Sound, Natural Teeth. Please refer to the certificate for a full and detailed explanation of benefit. Subject to deductible and coinsurance.

Unless otherwise mentioned, deductibles, co-pays, coinsurance and benefits are considered on a Per Injury/Sickness basis.

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Claims Submission

Documents required for submitting a claim include the following:

1. Completed Proof of Loss (Claim form) - can be found at: http://www.sevencorners.com/forms/ProofofLossForm.pdf
2. Detailed bills for services received.
3. Receipts for payments made.
4. Any other supporting medical documentation pertinent to the claim.

Claims documents may be submitted via postal mail, fax, or email:
Seven Corners, Inc.
Attn. Claims
303 Congressional Blvd.
Carmel, IN 46032
UNITED STATES
Fax: (+01) 317-575-2256
Email: claims@sevencorners.com

Claims which do not require additional medical documentation are processed within 30-45 days of receipt. Member reimbursement may be issued via bank check or wire transfer, depending on the member's preference. It is important to answer all questions on the claim form with as much detail as possible.

Currency conversions for claims are paid based on the exchange rate for the U.S. dollar on your date of service.