

STUDENT ACCIDENT & SICKNESS INSURANCE PLAN

**2010-2011
Academic Year**

Designed for Students of



Francis Tuttle Technology Center (“The Policyholder”) Oklahoma City, OK 73142

It is only through your status as a student at Francis Tuttle Technology Center that this Insurance Plan is available.

Policy Number: CHH0087751

Underwriter Reference Number: CAS9499839

Underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa. (“The Company”) with its principal place of business in New York, NY

-----CUT AND RETAIN-----

FRANCIS TUTTLE TECHNOLOGY CENTER

Student Accident & Sickness Plan Identification Card

Covered Student: _____
Student ID # _____

Policy Number: CHH0087751

Underwriter Reference Number: CAS9499839

Underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa. with its principal place of business in New York, NY
(See Reverse Side)

This brochure provides a brief description of the Student Accident & Sickness Program for eligible Students at Francis Tuttle Technology Center. This Program is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. The Master Policy contains complete details of the coverage and is the governing document. Inspection of the Master Policy may be made during business hours at the office of the College Administration.

ELIGIBILITY

All adult students enrolled in the career training programs at Francis Tuttle are automatically enrolled. High school students, short term classes, home study, correspondence, internet and television (TV) courses do not fulfill the eligibility requirements.

Optional Major Medical & Dependent Coverage is available to all enrolled students and their Dependents (see definition). Separate enrollment and premium are required and available at www.macori.com/FTTC. Details are provided on pages 4 and 5.

EFFECTIVE AND TERMINATION DATES

Students covered by this plan will be provided with twenty-four hour coverage, 7 days a week.

The policy will become effective at 12:01 a.m. on August 15, 2010. The Covered Person's coverage becomes effective either on the Effective Date of the Coverage Period for which he/she is enrolled and premium is paid; or the date enrollment is complete and premium is received, whichever is latest.

The policy will terminate at 11:59 p.m. on August 15, 2011. The Covered Person's coverage will terminate either on that date, or at the end of the period for which premium was paid, whichever is earlier.

COVERAGE PERIODS:

Fall *	08/16/10 to 01/16/11
Spring	01/17/11 to 08/15/11
Summer (New participants)	06/01/11 to 08/15/11

* 8/15/10 Coverage Effective date for Covered Persons maintaining continuous coverage from 09-10 Policy who: 1) are enrolling in this plan (without a break); and 2) who had an 8-14-10 Expiration Date.

NON-RENEWABLE ONE YEAR TERM INSURANCE

The Policy is a non-renewable one-year term Insurance. Similar coverage may be purchased for the following academic year. It is the Covered Person's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new policy year.

FOR COVERAGE AND CLAIMS INFORMATION

Students: Toll Free: 800-285-8133 Houston: 281-651-8787

Providers: Toll Free: 877-266-7778 Houston: 281-528-8949

PREFERRED PROVIDERS: First Health Network

www.firsthealth.com

Telephone: 1-800-226-5116



You may file a claim on-line at www.macori.com/FTTC.

Submit itemized medical bills to: Macori Administration, P. O. Box 2567, Spring, TX 77383-2567

This card is for identification purposes only. It is not a guarantee of benefits.

(Back)

PREFERRED PROVIDER ORGANIZATION (PPO)

You may call First Health at: 1-800-226-5116 (tell them you are a student at Francis Tuttle Technology Center) or check the website at: www.firsthealth.com for a listing of medical providers in the Oklahoma City area (or for other areas of the U.S.)

You are not required to utilize a First Health provider; however, in order to maximize the benefits offered under this plan, you should seek treatment from the First Health provider network when possible. The First Health Network consists of Hospitals, Doctors, and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates. Reimbursement rates for Eligible Expenses will vary according to the source of care.

PLANS AVAILABLE THROUGH FRANCIS TUTTLE TECHNOLOGY CENTER ARE:

- I. Basic Student Accident & Limited Sickness Insurance Plan
- II. Optional Major Medical & Dependent Coverage

- SCHEDULE OF BENEFITS -

I. BASIC PLAN

Deductible: \$10 for each Accident or Sickness.

Accident: If an Injury is sustained, while coverage is in force, and requires treatment within the 30 days after the date of the Accident causing the Injury, the plan will pay the Reasonable & Customary charges, or the amount listed below, if less, for Eligible Expenses up to an aggregate limit of \$5,000 for any one Accident.

Sickness: If Eligible Expenses are incurred due to Sickness while coverage is in force, the plan will pay the Reasonable & Customary charges, or the amount listed below, if less, not to exceed \$200 per Sickness.

Eligible Expenses include:

1. Medical and surgical treatment by a Doctor (excluding manipulation and massage);
2. Hospital confinement (room & board benefits limited to average semi-private rate);
3. Miscellaneous hospital expenses necessary for treatment such as: (a) X-ray examinations, (b) laboratory tests, (c) anesthesia supplies, (d) drugs or medicines, (e) surgical supplies, (f) operating room, (g) plaster casts, (h) therapeutic services, (i) pre-admission testing;
4. Dental treatment made necessary by injury to sound, natural teeth. Maximum \$250 per tooth;
5. Professional ambulance in an emergency;
6. Outpatient lab and X-ray;
7. Prescription drugs when prescribed by the attending Doctor. Maximum \$100 for each Accident or Sickness.

No service or supply will be provided unless specifically listed above.

SUPPLEMENTAL ACCIDENT BENEFIT FOR STUDENTS ONLY

When \$5,000 of Eligible Expenses has been **paid** under the Basic Plan for an Accident, this Supplemental Benefit will pay 80% of the Reasonable & Customary charges for the Eligible Expenses incurred not to exceed a Maximum Benefit of \$20,000 for all benefits paid under the Basic Plan and this Supplemental Benefit for any one Accident. Hospital room and board benefits are limited to the average semi-private rate.

II. OPTIONAL MAJOR MEDICAL & DEPENDENT COVERAGE

ENROLLMENT PROCEDURE

Basic Plan Benefits are provided to each eligible student. The Optional Major Medical & Dependent Coverage provides additional Accident and Sickness coverage. This optional coverage may be purchased on a voluntary basis at initial enrollment each policy year at www.macori.com/FTTC

ENROLLMENT DEADLINE

The deadline for purchasing Optional Major Medical & Dependent Coverage is within 30 days from eligible student's initial enrollment each Policy Year at www.macori.com/FTTC.

STUDENTS: Covered Students are eligible to purchase this Optional Major Medical Plan to increase benefits for Accident and Sickness. Students receive an additional \$5,000 per covered Accident (\$25,000 total for the Basic and Optional Major Medical Plans); and an additional \$24,800 per covered Sickness (\$25,000 total for the Basic and Optional Major Medical Plans).

DEPENDENTS: Covered Students may also purchase Dependent Coverage for their eligible Dependents. Covered students must be enrolled in the Optional Major Medical Plan to purchase Dependent Coverage.

The combined lifetime maximum benefit payable for Basic and Optional Major Medical is \$25,000 per Accident or Sickness. This lifetime benefit is the maximum amount of benefits the Company will pay while the Covered Person is covered under the Policy and any other Policy issued to the Policyholder by the Company and is inclusive and cumulative of any and all periods. Any charges incurred for an Injury sustained or a Sickness that began prior to the Covered Person's effective date of coverage under the Optional Major Medical Plan will not be Eligible Expenses for purposes of benefit payment for the first 12 months following the effective date of Optional Major Medical Plan under the Policy.

A. ACCIDENT ELIGIBLE EXPENSE BENEFITS FOR DEPENDENTS

Deductible: \$10 for each Accident

If Injury is sustained, while coverage is in force, and requires treatment within 30 days, the plan will pay either the Reasonable and Customary charge, or the amount listed below, if less, for Eligible Expenses not to exceed an aggregate limit of \$5,000 for any one Accident.

Eligible Expenses include:

1. Medical and surgical treatment by a Doctor (excluding manipulation or massage);
2. Hospital confinement (room & board benefits limited to average semi-private rate);
3. Miscellaneous hospital expense necessary for treatment, such as: (a) X-ray examinations, (b) laboratory tests, (c) anesthesia supplies, (d) drugs or medicines, (e) surgical supplies, (f) operating room, (g) plaster casts, (h) therapeutic services, (i) pre-admission testing;
4. Outpatient lab and X-ray;
5. Dental treatment made necessary by injury to sound natural teeth. Maximum \$250 per tooth;
6. Professional ambulance in an emergency;
7. Prescription drugs when prescribed by the attending Doctor. Maximum \$100.

OPTIONAL MAJOR MEDICAL & DEPENDENT COVERAGE, Continued

B. SICKNESS ELIGIBLE EXPENSE

If a Sickness requires treatment, the plan will pay either the Reasonable and Customary charges, or the amount listed below, if less, for Eligible Expenses not to exceed an aggregate limit of \$5,000 for any one Sickness.

Eligible Expenses include:

1. **Daily Room and Board** when hospital confined up to \$200 per day to a maximum of \$3,600.
2. **Miscellaneous Hospital Charges** for use of operating room, anesthesia (including administration thereof), drugs or medicines, therapeutic services or supplies when hospital confined and while receiving room and board benefits above, up to a maximum of \$1,000.
3. **Hospital Outpatient Expenses** (not including drugs and medications) up to \$250.
4. **Surgery** performed by a Doctor, in accordance with the Relative Value Studies Unit having a conversion factor of \$30 up to a maximum of \$5,000. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one such procedure for which the largest benefit is payable. This benefit is not payable in addition to Doctor's Visits.
5. **Doctor's Visits** when hospital confined, up to \$50 per visit per day not to exceed a maximum of \$500 for each Sickness; or when not hospital confined up to \$50 per visit per day, not to exceed a maximum of \$500 for each Sickness. Payment shall not be made for: (a) manipulation or massage or; (b) medical treatment received on the day of any surgical operation or during convalescence therefrom if a Surgery benefit is payable.
6. **Diagnostic X-ray and Laboratory Procedures** prescribed by the attending Doctor for a diagnosed Sickness up to a maximum of \$250 each procedure.
7. **Professional Ambulance Expense** \$150 per trip to a maximum of \$300 per policy year.
8. **Prescription Drugs** when prescribed by the attending Doctor to a maximum of \$100 per Sickness per policy year up to \$500 Aggregate Maximum for all Sicknesses combined per Policy Year.

SUPPLEMENTAL BENEFITS

- C. STUDENTS:** When \$20,000 of Eligible Expenses has been **paid** under the Basic Plan & Supplemental Plans for an Accident or \$5,000 for a Sickness under the Basic and Optional Major Medical Plan, Supplemental Benefit will be paid at 80% of Reasonable and Customary charges for Eligible Expenses incurred not to exceed a Maximum Benefit of \$25,000 for all benefits under Basic and Optional Major Medical Plan for any one Accident or Sickness.

Hospital room and board benefits are limited to average semi-private room rate. Severe Mental Illness is paid as any other covered Sickness (all other mental and nervous disorders are excluded under the Optional Major Medical and Dependent Coverage). Prescription Drugs for Sickness are limited as outlined in #8 above.

D. DEPENDENTS: When \$5,000 of Eligible Expenses has been paid under the Optional Major Medical Dependent Coverage for an Accident or Sickness, this Major Medical Supplemental Benefit will pay 80% of the Reasonable and Customary charges for Eligible Expenses incurred, not to exceed a Maximum Benefit of \$25,000 for all benefits paid under the Optional Major Medical Dependent Coverage and this Major Medical Supplemental Benefits for any one Accident or Sickness. *Hospital room and board benefits are limited to the average semi-private room rate. Severe Mental Illness is paid as any other covered Sickness (all other mental and nervous disorders are excluded under the Optional Major Medical and Dependent Coverage). Prescription Drugs for Sickness are limited as outlined in #8 above.*

EXTENSION OF BENEFITS

If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that hospital confinement. Such benefits will be payable until the earliest of: (1) the date the hospital confinement ends; (2) the end of the 30 day period following the date his or her coverage terminates; or (3) the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

MANDATED BENEFITS: This plan also covers all applicable mandated benefits as required by the State of Oklahoma. For complete details, please review the Policy on file at the Institution.

NON DUPLICATION OF COVERAGE: If benefits are payable under more than one provision in the policy, then benefits will be provided only under the provision providing the greater benefit.

COORDINATION OF BENEFITS: The Policy will coordinate benefits with any valid insurance or plan as described in the Policy.

REFUND OF PREMIUM: Premiums received by the Company will be considered fully earned and nonrefundable. Refund of premium will be considered only if it is determined that the Covered Person did not meet the eligibility requirements at time of enrollment.

EXCLUSIONS

Unless mandated by Oklahoma or such coverage is provided elsewhere in the Policy, the Policy does not cover nor provide benefits for Loss or Expenses incurred:

1. as a result of dental treatment, or dental x-rays except for treatment resulting from Injury to sound natural teeth.
2. for services normally provided without charge by the Policyholder or by health care providers employed by the Policyholder.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such; orthodontic appliances or prescriptions or examinations for such.
4. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
5. for Accident or Sickness resulting from war or act of war, declared or undeclared, while serving in the military forces or any auxiliary unit attached thereto.
6. as a result of an Accident or Sickness for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law.

EXCLUSIONS, Continued

7. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
8. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
9. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This provision does not apply in any state where prohibited.
10. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, or insurrection.
11. for elective treatment or elective surgery or complications arising therefrom; voluntary or elective abortions, elective sterilization or its reversal unless otherwise provided in the Policy.
12. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
13. for any services rendered by a Covered Person's immediate family member.
14. for a treatment, service or supply which is not Medically Necessary.
15. as a result of suicide or any attempt at suicide, or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
16. for surgery and/or treatment of hernia of any kind.
17. for manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, applications of heat or cold.
18. for loss due to voluntary use of any drug, narcotic or controlled substance, unless prescribed by a Doctor.
19. for routine medical care, physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy other than Hospital nursery expense of a Dependent newborn baby. This exclusion does not apply with respect to coverage for child health supervision services, if covered under the Policy, as mandated by the state of Oklahoma pursuant to Title 36 §3203 of the Oklahoma Insurance Code.
20. for Injury resulting from travel in or upon a snowmobile, ATV (all terrain or similar type two or three-wheeled vehicle and/or off-road four wheeled motorized vehicles), personal watercraft, bobsledding or bungee jumping.
21. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, varsity, professional sports activity, including travel to and from the activity and practice.
22. for Injury resulting from fighting, except in self-defense.
23. for treatment, services, drugs, device, procedures or supplies that are experimental or investigational.
24. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
25. for blood or blood plasma, except for charges by a Hospital for the processing or administration of blood.

PRE-EXISTING CONDITIONS LIMITATION: Pre-existing Conditions are not covered for the first 12 months following a Covered Person's effective date of coverage under the Policy.

This limitation will not apply if:

- (a) the Covered Person has been covered under the Policyholder's prior Policy for 12 consecutive months immediately preceding the effective date of coverage under the current Policy; or
- (b) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. Credit will be given for the time the individual was covered under the prior Creditable Coverage; and (1) the individual's most recent prior Creditable Coverage was under an employer group plan; and (2) the individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her; and (3) the individual is not eligible for coverage under any other group health plan, Medicare or Medicaid; and (4) the individual does not have other health insurance.

DEFINITIONS

"Accident" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

"Covered Person" means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

"Covered Student" means a student of the Policyholder who is insured under the Policy.

"Deductible/Deductible Amount" means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

"Dependent" means: (a) the Covered Student's spouse residing with the Covered Student; and (b) the Covered Student's unmarried child under age 19 who is dependent upon the Covered Student for support.

"Doctor" means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified

by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's immediate family member.

"Eligible Expense" means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Accident: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person.

"Hospital" means a facility which meets all of these tests: (a) it provides in-patient services for the care and treatment of injured and sick people; and (b) it provides room and board services and nursing services 24 hours a day; and (c) it has established facilities for diagnosis and major surgery; and (d) it is supervised by a Doctor; and (e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and (f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

DEFINITIONS, Continued

“Hospital,” Continued ...Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for mental or nervous disorders or substance abuse.

The term "Hospital" includes (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Accident based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is experimental/ investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

“Pre-Existing Condition” means a Sickness or Accident for which medical care, treatment, diagnosis or advice was received or recommended during the 6 months immediately preceding the Covered Person’s effective date of coverage under the Policy or a pregnancy existing on the Covered Person’s effective date of coverage under the Policy.

“Reasonable and Customary” means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Sickness” means illness, disease and complications of pregnancy, including related conditions and recurrent symptoms of the Sickness, which begin after the effective date of a Covered Person’s coverage. All Sicknesses due to the same or a related cause are considered one Sickness.

CERTIFICATE OF CREDITABLE COVERAGE

Coverage under this health plan is "creditable coverage" under Federal Law. When the Covered Person's coverage terminates, he or she can request a Certificate of Creditable Coverage, which is evidence of coverage under this health plan. The Covered Person may need such a certificate if he or she becomes covered under a group health plan or other health plan within 63 days after his or her coverage under this health plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions the Covered Person had before enrolling, this Certificate may be used to reduce or eliminate those exclusions or limitations. In order to obtain a Certificate of Creditable Coverage, the Covered Person should complete a Certificate of Creditable Coverage request form at www.macori.com/FTTC or send a written request to:

Macori Administration
P.O. Box 2567, Spring, Texas 77383-2567

HOW TO FILE A CLAIM

1. **In the event of an Accident or Sickness, the Covered Person should seek immediate medical care. (See Preferred Provider Information on page 3).**
2. Secure a Company Claim Form while visiting the on-campus health care facility or by logging on to www.macori.com/FTTC.
3. Mail itemized hospital and/or medical bills to the Claims Office:

Macori Administration
c/o Macori, Inc.
P. O. Box 2567, Spring, TX 77383-2567
Toll Free: 1-800-285-8133 ~ Fax: 281-651-8808

Please do not depend on the medical provider to file the claim form! Only one claim form is required per Sickness/Accident. After filing the initial claim, additional bills may be forwarded with name, Student ID and school name/Policy number.

Questions and Correspondence should be directed to:


MACORI, INC.
Health Insurance for Students/Scholars

Agency:
Macori, Inc.

Claims Office:
Macori Administration

P. O. Box 2567, Spring, Texas 77383-2567

TOLL FREE: 1-800-285-8133 ~ HOUSTON METRO: 281-651-8787

Website: www.macori.com/FTTC Email: macori@macori.com

UNDERWRITTEN BY:

*National Union Fire Insurance Company of Pittsburgh, Pa.
with its principal place of business in New York, NY*

"We value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more privacy information, please go to www.macori.com.

All benefits provided on a verbal basis are conditional and subject to final determination when the claim is filed with the insurance company.

Please keep this brochure as a general summary of the insurance under policy series S30494NUFIC-OK. The Policy on file at the Institution contains all of the provisions, limitations, exclusions and definitions of the insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between brochure and Policy, the Policy will govern and control the payment of benefits.