

AMERISAFE, INC

2011 Benefits Program

AMERISAFE, INC is pleased to offer a summary guide to your comprehensive benefits program.

We are committed to providing you and your family with quality products at an affordable cost.

The following information will give you an overview of your benefit options.





WHO IS ELIGIBLE?

If you are employed with AMERISAFE and work a minimum of 30 hours or more per week, you are eligible for company benefits.

WHEN DO I ENROLL?

Existing employees: In 2011, you will have just one opportunity to enroll during Open Enrollment October 15th through November 14th.

New hires: AMERISAFE has a **90-day Waiting Period** with coverage effective the first day of the month following the 90 days. If the first of the month coincides with the last day of your 90-day Waiting Period, your coverage will be effective that day.

Once you make your election, you cannot change your election until the following anniversary (January 1, 2012). Exceptions are qualifying events such as termination of employment, marriage, death, divorce, birth of a child, adoption, moving part time to full time or vice versa, spouse's Open Enrollment, etc.

WHAT BENEFITS ARE PRE-TAX?

Premiums for the following benefits are deducted from your paycheck pre-tax:

- Medical
- Voluntary Gap Coverage
- Dental
- Vision
- Worksite Products, such as Critical Illness and Cancer

All employees should take this opportunity to review the benefits offered under AMERISAFE's employee benefits program and decide which benefits will create the ideal package for you. The final date to enroll is November 14, 2010; **there will be NO exceptions.**

Open Enrollment this year is a "negative" enrollment, meaning if you do not wish to make **any changes** to your current elections, you do not need to enroll online (with the exception of the FSA enrollment which **must** be completed each year). If you are a new enrollee, or if you would like to make changes to your current elections, please complete the appropriate online enrollment information no later than noon on November 14th.

Rebekah Fontenot is available to assist you in the event of any questions or concerns regarding Open Enrollment. She can be reached at (800) 256-9052 or via email at rfontenot@amerisafe.com.

Sincerely,

Rebekah Fontenot

Medical

Aetna

Customer Service: (888) 982-3862

www.aetna.com

Employee Contributions

Coverage Level	Semi-Monthly Contributions (24 Pay Periods)	Monthly Contributions (12 Pay Periods)
Employee Only	\$24.50	\$49.00
Employee + Spouse	\$152.00	\$304.00
Employee + Child(ren)	\$117.00	\$234.00
Employee + Family	\$191.00	\$382.00

Brief Summary of Benefits

(Please refer to your Certificate of Coverage for further details)

Covered Benefit	In-Network	Out-of-Network
HRA (1 st Dollar Benefit, credited towards deductible)	\$500 Individual / \$1,000 Family	
Deductible	\$2,000 Individual / \$4,000 Family	\$2,000 Individual / \$4,000 Family
HRA Amounts prorated monthly for new hires. No proration for family coverage. Change to new tier based on new employee status. Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's coverage terminates.		
Unused amounts rolled over into following year(s).		
Coinsurance	90%	70%
OOP Max (Excludes Deductible)	\$1,500 Individual / \$3,000 Family	\$1,500 Individual / \$3,000 Family
Office Visit Copay	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Lifetime Maximum	Unlimited	
Prescription Drugs (Retail)	\$15 / \$25 / \$40	
Prescription Drugs (Mail Order)	\$30 / \$50 / \$80	

PLEASE NOTE: If this summary of benefits conflicts in any way with your Medical Certificate of Coverage, the Medical Certificate of Coverage shall prevail.

Flexible Spending Account (FSA)

TASC

Customer Service: (800) 422-4661

www.tasconline.com

Account Type	Contribution
Dependent Care FSA	\$5,000 if married and filing jointly; \$2,500 if separated and filing separate tax returns
Medical FSA	\$3,600 per Calendar Year

****AMERISAFE offers an end of the year grace period of 90 days, or March 31, 2011, for expenses incurred through December 31, 2010.****

****Beginning January 1, 2011, OTC medications are no longer a qualifying FSA purchase without a written prescription (insulin excluded). It is your responsibility to ensure that any purchases you make using your FSA debit card are valid expenses.****

Examples of Eligible Medical Expenses

(Please note that this is an abbreviated list and is for illustrative purposes only)

Acupuncture	Insulin
Artificial Limbs	Laser Eye Surgery / LASIK
Bandages	Nasal Strips
Birth Control / Contraceptive Devices	Pregnancy Test
Contact Lenses & Contact Lens Solution	Prenatal Vitamins

Examples of Eligible Medicines and Drugs

(Please note that this is an abbreviated list and is for illustrative purposes only)

REMEMBER...purchases after 12/31/2010 will require a letter of medical necessity or prescription for reimbursement

Bengay, Flexall, Pain Relieving Creams or Gels	Indigestion or Antacid Relievers
Calamine Lotion	Laxatives
Corn Removal	Sinus Medicines
Diaper Rash Ointment	Teething Gel
Hydrogen Peroxide or Rubbing Alcohol	Wart Removal Medication

Examples of Ineligible Expenses

(Please note that this is an abbreviated list and is for illustrative purposes only)

Athletic Mouth Guards	Deodorant
Auto Insurance Providing Medical Coverage	Dental Floss
Chapstick/Lip Balm	Exercise Equipment and Fees
Cosmetic Surgery	Eye Drops for General Comfort
Cosmetic Dentistry	Hand Sanitizer

Examples of Eligible Dependent Care Expenses

(Please note that this is an abbreviated list and is for illustrative purposes only)

Day Camp (primary purpose must be custodial care and not educational in nature)	Dependent care expenses that are necessary for you (and your spouse) to work, actively look for work or attend school full time
Dependent care for child under age 13	Late pick up fees
FICA/FUTA taxes of day care provider	Nanny expenses attributed to dependent care
Nursery school (preschool)	Registration fees (when allocated to dependent care services that have been provided)

Examples of NON-Eligible Dependent Care Expenses

(Please note that this is an abbreviated list and is for illustrative purposes only)

Transportation to and from the place where dependent care services are provided	Food, clothing and education
Expenses for which federal child care tax credits are taken, or are claimed under Healthcare FSA	Tuition

PLEASE NOTE: If this summary of benefits conflicts in any way with your FSA Plan Document, the FSA Plan Document shall prevail.

Other Medical Related Contact Information

Vendor Type	Vendor Name	Vendor Phone	Vendor Website
COBRA Administration	Meritain	(800) 256-2657	www.mymeritain.com

Dental

United Concordia

Customer Service: (800) 332-0366

www.UnitedConcordia.com

Low Option Premiums

Coverage Level	Semi-Monthly Contributions (24 Pay Periods)	Monthly Contributions (12 Pay Periods)
Low Option with Medical		
Employee Only	\$7.155	\$14.31
Employee + 1	\$16.00	\$32.00
Employee + 2 or more	\$20.565	\$41.13
Low Option without Medical		
Employee Only	\$0	\$0
Employee + 1	\$0	\$0
Employee + 2 or more	\$0	\$0

High Option Premiums

Coverage Level	Semi-Monthly Contributions (24 Pay Periods)	Monthly Contributions (12 Pay Periods)
High Option with Medical		
Employee Only	\$8.95	\$17.90
Employee + 1	\$19.595	\$39.19
Employee + 2 or more	\$26.495	\$52.99
High Option without Medical		
Employee Only	\$1.795	\$3.59
Employee + 1	\$3.595	\$7.19
Employee + 2 or more	\$5.93	\$11.86



Brief Summary of Benefits
(Please refer to your Certificate of Coverage for further details)

Covered Benefit	Low Option	High Option
Deductible	\$75 / 3x Family	
Preventive Procedures	Covered at 80%, deductible waived Preventive incentive is included. This means that preventive care does not accrue toward the Annual Maximum.	
Basic Procedures	Covered at 80%, after deductible	
Major Procedures	Covered at 50%, after deductible	
Calendar Year Maximum	\$1,000 per covered person	\$2,000 per covered person
Orthodontia	Covered at 50% (adult and child) \$1,000 lifetime maximum per covered person	

PLEASE NOTE: If this summary of benefits conflicts in any way with your United Concordia Certificate of Coverage, the Certificate of Coverage shall prevail.

Voluntary Vision

Davis Vision

Customer Service: (877) 923-2847

www.davisvision.com

(Please use client code **4835** when attempting to access the network)

Premiums

Coverage Level	Semi-Monthly Premiums (24 Pay Periods)	Monthly Premiums (12 Pay Periods)
Employee Only	\$4.30	\$8.60
Employee + Spouse	\$7.75	\$15.49
Employee + Child(ren)	\$8.17	\$16.34
Employee + Family	\$12.91	\$25.81

Brief Summary of Benefits
(Please refer to your Certificate of Coverage for further details)

In-Network

Covered Benefit	Coverage	
Copays	Exam	\$10
	Spectacle Lenses	\$10
	Spectacle Frames	Fashion Level: Included in \$10 copay Designer Level: Included in \$10 copay Premier Level: \$25 Non-Collection Frame Allowance: Up to \$130, plus a 20% discount on any overage
	Contact Lenses in lieu of eyeglasses (Fitting fee covered up to \$60)	Davis Vision Collection: \$10 Non-Collection Allowance: Up to \$130, Plus a 15% discount on any overage
Frequency	Exam	Once per 12 months
	Eyeglass Lenses	Once per 12 months
	Frames	Once per 24 months
	Contact Lens Evaluation, Fitting & Follow-Up Care	Once per 12 months
	Contact Lenses (in lieu of glasses)	Once per 12 months

Out-of-Network (Same frequencies apply)

Covered Benefit		Coverage
Eye Exams		Covered up to \$30
Frames		Covered up to \$30
Eyeglass Lenses	Single Lenses	Covered up to \$25
	Bifocal Lenses	Covered up to \$35
	Trifocal Lenses	Covered up to \$45
	Lenticular Lenses	Covered up to \$60
Contact Lenses	Medically Necessary	Covered up to \$225
	Elective	Covered up to \$75

PLEASE NOTE: If this summary of benefits conflicts in any way with your Davis Vision Certificate of Coverage, the Certificate of Coverage shall prevail.

Basic Life and AD&D

Lincoln Financial

Customer Service: (800) 423-2765

www.lincolnfinancial.com

This benefit is offered **at no cost to you!!** You receive a flat \$50,000.

Voluntary Life

Lincoln Financial

Customer Service: (800) 423-2765

www.lincolnfinancial.com

Rates

Employee Age	Semi-Monthly Rate (24 Pay Periods) per \$1,000 of Benefit	Monthly Rate (12 Pay Periods) per \$1,000 of Benefit
0 to 29	\$0.045	\$0.090
30 to 34	\$0.050	\$0.100
35 to 39	\$0.060	\$0.120
40 to 44	\$0.090	\$0.180
45 to 49	\$0.155	\$0.310
50 to 54	\$0.270	\$0.540
55 to 59	\$0.420	\$0.840
60 to 64	\$0.560	\$1.120
65 to 69	\$0.980	\$1.960
70 to 74	\$1.555	\$3.110
75+	\$2.420	\$4.840
Child(ren) Rate (Regardless of # of Children)	\$1.00 for \$10,000 of coverage	\$2.00 for \$10,000 of coverage

Brief Summary of Benefits
(Please refer to your Certificate of Coverage for further details)

Covered Benefit	Covered Person	Benefit Amount
Benefit Schedule	Employee	\$10,000 increments to a maximum of \$500,000 (for employees 70 and over, maximum is \$50,000)
	Spouse	\$5,000 increments to a maximum of \$250,000
	Child(ren)	14 days to 6 months: \$250 6 months to 26 years: \$10,000
Guarantee Issue	Employee	Employees to age 69: \$200,000 Employees ages 70 to 74: \$25,000 Employees age 75+: Not eligible for Guarantee Issue
	Spouse	Spouses to age 69: \$50,000 Spouses age 70 to 74: \$25,000 Spouses age 75+: Not eligible for Guarantee Issue
	Child(ren)	14 days to 6 months: \$250 6 months to 26 years: \$10,000
Age Reduction Schedule		50% at age 70
Waiver of Premium		To age 65

Spousal rate is based on employee's date of birth.

NOTE: Spousal benefit may not exceed 50% of employee's benefit.

At annual enrollment, existing enrollees can elect an additional \$40,000 (in \$10,000 increments) without EOI regardless of the Guarantee Issue limit. Existing participating spouses can elect an additional \$20,000 (in \$5,000 increments) without EOI regardless of the Guarantee Issue limit.

One-time true Open Enrollment for those who have not previously elected the Voluntary Life, without EOI, up to the GI amount. This offer is valid only between October 15th and November 14th.

PLEASE NOTE: If this summary of benefits conflicts in any way with your Lincoln Financial Certificate of Coverage, the Certificate of Coverage shall prevail.

Voluntary Short-Term Disability

Lincoln Financial

Customer Service: (800) 423-2765

www.lincolnfinancial.com

\$0.530 monthly (\$0.265 Semi-Monthly) per \$10 of benefit

Brief Summary of Benefits
(Please refer to your Certificate of Coverage for further details)

Covered Benefit	Benefit Amount
Benefit Percentage	60% of weekly earnings
Benefits Begin	15 th day accident/sickness
Maximum Benefit	\$1,250 weekly
Benefit Duration	11 weeks

PLEASE NOTE: If this summary of benefits conflicts in any way with your Lincoln Financial Certificate of Coverage, the Certificate of Coverage shall prevail.

Voluntary Long-Term Disability

Lincoln Financial

Customer Service: (800) 423-2765

www.lincolnfinancial.com

\$0.580 monthly (\$0.290 Semi-Monthly) per \$100 of covered payroll

Brief Summary of Benefits

(Please refer to your Certificate of Coverage for further details)

Covered Benefit	Benefit Amount
Benefit Percentage	60% of monthly earnings
Maximum Benefit	\$5,000 monthly
Minimum Benefit	\$50 monthly
Elimination Period	90 days
Social Security Integration	Family
Own Occupation	24 months
Pre-Existing Condition Limitation	3/12
Drug & Alcohol Abuse	24 months
Additional Benefits	10% progressive income benefit Family Care: \$250 for 12 months

PLEASE NOTE: If this summary of benefits conflicts in any way with your Lincoln Financial Certificate of Coverage, the Certificate of Coverage shall prevail.

Voluntary GAP

American Fidelity

Customer Service: (877) 967-5748

www.afadvantage.com

Semi-Monthly Rates (24 Pay Periods) for \$1,000 Plan

Coverage Level	Under Age 55	Ages 55-59	Ages 60+
Employee Only	\$8.50	\$12.00	\$18.00
Employee + Spouse	\$15.50	\$21.50	\$32.50
Employee + Child(ren)	\$14.00	\$17.50	\$23.50
Employee + Family	\$21.00	\$27.00	\$38.00

Monthly Rates (12 Pay Periods) for \$1,000 Plan

Coverage Level	Under Age 55	Ages 55-59	Ages 60+
Employee Only	\$17.00	\$24.00	\$36.00
Employee + Spouse	\$31.00	\$43.00	\$65.00
Employee + Child(ren)	\$28.00	\$35.00	\$47.00
Employee + Family	\$42.00	\$54.00	\$76.00

Brief Summary of Benefits
(Please refer to your Certificate of Coverage for further details)

Covered Benefit	Benefit Description
In-Hospital	Pays the difference between the ACTUAL Hospital expenses you incur and the amount payable by your primary medical plan for the out-of-pocket covered charges. Pays up to the maximum benefit selected per confinement.
Outpatient	Pays the difference between the ACTUAL Out-Patient expenses you incur and the amount paid by your primary medical plan for the out-of-pocket covered charges, up to a maximum out-patient benefit of \$200
Physician Visits	Physician Visits up to \$25 per visit, for up to five visits (\$125) per family per calendar year

PLEASE NOTE: If this summary of benefits conflicts in any way with your American Fidelity Certificate of Coverage, the Certificate of Coverage shall prevail.

Voluntary Long-Term Care

UNUM

Customer Service: (888) 868-6745

www.unumprovident.com

Semi-Monthly Rates (24 Pay Periods)

Insurance Age	Plan A Base Plan	Plan B Base Plan w/ Non Forfeiture Option	Plan C Base Plan w/ Compound Inflat Option	Plan D Base Plan w/ Non Forfeiture Compound Inflat Option
18-30	\$1.50	\$1.80	\$4.80	\$5.80
31	\$1.55	\$1.90	\$4.95	\$6.00
32	\$1.55	\$1.90	\$5.05	\$6.10
33	\$1.60	\$1.95	\$5.20	\$6.30
34	\$1.65	\$2.00	\$5.30	\$6.45
35	\$1.70	\$2.10	\$5.50	\$6.65
36	\$1.75	\$2.15	\$5.60	\$6.80
37	\$1.85	\$2.25	\$5.80	\$7.00
38	\$1.90	\$2.30	\$6.00	\$7.25
39	\$2.00	\$2.40	\$6.15	\$7.35
40	\$2.05	\$2.50	\$6.30	\$7.55
41	\$2.15	\$2.55	\$6.45	\$7.75
42	\$2.25	\$2.70	\$6.70	\$7.95
43	\$2.35	\$2.80	\$6.90	\$8.20
44	\$2.50	\$2.95	\$7.15	\$8.50
45	\$2.65	\$3.10	\$7.35	\$8.70
46	\$2.75	\$3.25	\$7.60	\$8.95
47	\$2.90	\$3.40	\$7.75	\$9.15

Insurance Age	Plan A Base Plan	Plan B Base Plan w/ Non Forfeiture Option	Plan C Base Plan w/ Compound Inflat Option	Plan D Base Plan w/ Non Forfeiture Compound Inflat Option
48	\$3.05	\$3.55	\$8.00	\$9.40
49	\$3.15	\$3.70	\$8.25	\$9.65
50	\$3.30	\$3.90	\$8.45	\$9.90
51	\$3.50	\$4.10	\$8.75	\$10.25
52	\$3.70	\$4.35	\$9.10	\$10.60
53	\$3.95	\$4.55	\$9.35	\$10.85
54	\$4.15	\$4.80	\$9.70	\$11.25
55	\$4.45	\$5.15	\$10.10	\$11.75
56	\$4.70	\$5.45	\$10.50	\$12.20
57	\$5.05	\$5.85	\$11.00	\$12.75
58	\$5.40	\$6.25	\$11.55	\$13.40
59	\$5.80	\$6.70	\$12.05	\$14.00
60	\$6.20	\$7.20	\$12.60	\$14.60
61	\$6.80	\$7.90	\$13.55	\$15.70
62	\$7.45	\$8.55	\$14.55	\$16.75
63	\$8.15	\$9.40	\$15.50	\$17.85
64	\$8.95	\$10.30	\$16.70	\$19.20
65	\$10.15	\$11.65	\$18.50	\$21.30
66	\$11.25	\$12.80	\$20.00	\$22.80
67	\$12.45	\$14.20	\$21.80	\$24.85
68	\$13.80	\$15.70	\$23.45	\$26.75
69	\$15.25	\$17.35	\$25.35	\$28.90
70	\$16.85	\$19.20	\$27.30	\$31.15
71	\$18.70	\$21.15	\$29.85	\$33.75
72	\$20.70	\$23.40	\$32.45	\$36.65
73	\$22.90	\$25.65	\$35.05	\$39.25
74	\$25.30	\$28.35	\$38.00	\$42.55
75	\$30.45	\$33.80	\$44.80	\$49.75
76	\$33.45	\$37.10	\$48.60	\$53.95
77	\$36.65	\$40.35	\$52.30	\$57.50
78	\$40.20	\$44.20	\$56.50	\$62.15
79	\$44.05	\$48.45	\$60.70	\$66.75
80	\$48.30	\$53.15	\$65.65	\$72.25

Brief Summary of Benefits
(Please refer to your Certificate of Coverage for further details)

Covered Benefit	Benefit Description
Elimination Period	90 days
Facility Benefit Duration	6 years
Lifetime Maximum	\$72,000
Facility Monthly Benefit	\$1,000
Home Monthly Benefit	\$500
Home Care Level	Professional

NOTES:

- 1) Guarantee issue up to \$4,000/month for employees within initial eligibility
- 2) Late enrollees will be subject to EOI
- 3) The rates will not increase because you grow older, or because of your use of the benefits.

PLEASE NOTE: If this summary of benefits conflicts in any way with your UNUM Certificate of Coverage, the Certificate of Coverage shall prevail.

Voluntary Cancer

Allstate

Customer Service: (800) 348-4489

www.allstate.com

Low Option Premiums

Coverage Level	Semi-Monthly (24 Pay Periods)	Monthly (12 Pay Periods)
Individual	\$5.54	\$11.08
Family	\$9.26	\$18.52

High Option Premiums

Coverage Level	Semi-Monthly (24 Pay Periods)	Monthly (12 Pay Periods)
Individual	\$9.75	\$19.50
Family	\$16.28	\$32.56

Brief Summary of Benefits
(Please refer to your Policy for further details)

Benefit	Low Option	High Option
Continuous Hospital Confinement	\$100/day (70 days max)	\$200/day (70 days max)
Extended Benefits	Up to \$100/day	Up to \$200/day
Government or Charity Hospital	\$100/day	\$200/day
Surgery	Up to \$1,500*	Up to \$3,000*
Second Surgical Opinion	Up to \$200	Up to \$400
Anesthesia	Up to 25% of surgery benefit	Up to 25% of surgery benefit
Ambulatory Surgical Center	Up to \$250	Up to \$500
Radiation/Chemotherapy	Up to \$5,000/12 months	Up to \$10,000/12 months
Comfort/Anti-Nausea Benefit	Up to \$200 per CY	Up to \$200 per CY
Inpatient Drugs and Medicine	Up to \$25/day	Up to \$25/day
Private Duty Nursing	Up to \$100/day	Up to \$200/day

Benefit	Low Option	High Option
New or Experimental Treatment	Up to \$5,000/12 months	Up to \$5,000/12 months
Blood, Plasma and Platelets	Up to \$5,000/12 months	Up to \$10,000/12 months
Physician's Attendance	Up to \$50/day	Up to \$50/day
At Home Nursing	Up to \$100/day	Up to \$200/day
Prosthesis	Up to \$2,000/amputation	Up to \$2,000/amputation
Ambulance	Up to \$100	Up to \$100
Hospice Care	1) Up to \$100/day Or 2) Up to \$100/visit (1 visit/day max)	1) Up to \$200/day Or 2) Up to \$200/visit (1 visit/day max)
Outpatient Lodging	Up to \$50/day, Up to \$2,000/12 months	Up to \$50/day, Up to \$2,000/12 months
Non-Local Transportation	Coach fare or \$0.40/mile	Coach fare or \$0.40/mile
Family Member Lodging and Transportation	1) Up to \$50/day 2) Coach fare or \$0.40/mile	1) Up to \$50/day 2) Coach fare or \$0.40/mile
Extended Care Facility	Up to \$100/day	Up to \$200/day
Physical or Speech Therapy	Up to \$50/day	Up to \$50/day
Waiver of Premium?	Yes	Yes
Cancer Screening Benefit	\$100/covered person/calendar year	\$100/covered person/calendar year
Cancer Initial Diagnosis (First Occurrence)	No Benefit	One-time benefit of \$1,000

NOTES:

- 1) *New Enrollees: Guarantee Issue*
- 2) *Late Enrollees: Subject to EOI*

PLEASE NOTE: If this summary of benefits conflicts in any way with your Allstate Policy, the Certificate of Coverage shall prevail.

Voluntary Critical Illness

Allstate

Customer Service: (800) 348-4489

www.allstate.com

Tobacco Premiums

Coverage Level	\$10,000		\$15,000	
	Semi-Monthly (24 Pay Periods)	Monthly (12 Pay Periods)	Semi-Monthly (24 Pay Periods)	Monthly (12 Pay Periods)
Employee Only	\$11.70	\$23.39	\$16.55	\$33.09
Employee + Spouse	\$17.61	\$35.21	\$24.78	\$49.55
Employee + Child(ren)	\$11.81	\$23.62	\$16.72	\$33.43
Employee + Family	\$17.72	\$35.44	\$24.95	\$49.90

Non-Tobacco Premiums

Coverage Level	\$10,000		\$15,000	
	Semi-Monthly (24 Pay Periods)	Monthly (12 Pay Periods)	Semi-Monthly (24 Pay Periods)	Monthly (12 Pay Periods)
Employee Only	\$7.10	\$14.19	\$9.65	\$19.29
Employee + Spouse	\$10.80	\$21.59	\$14.56	\$29.12
Employee + Child(ren)	\$7.22	\$14.43	\$9.83	\$19.65
Employee + Family	\$10.93	\$21.85	\$14.76	\$29.51

Brief Summary of Benefits
(Please refer to your Policy for further details)

Category	Covered Benefit	Coverage
Category 1	Heart Attack	\$10,000
	Heart Transplant	\$10,000
	Stroke	\$10,000
	Coronary Artery By-Pass Surgery	\$2,500
Category 2	Major Organ Transplant (other than heart)	\$10,000
	End Stage Renal Failure	\$10,000
	Paralysis (not as a result of stroke)	\$10,000
	Alzheimer's Disease	\$2,500

NOTES:

- 3) *\$100 Wellness Benefit (Cancer Screenings and Heart Screenings) included in above rates*
- 4) *Recurrence Benefit: 25% of previously paid Category 1 or 2 benefits*
- 5) *New Enrollees: Guarantee Issue*
- 6) *Late Enrollees: Subject to EOI*

PLEASE NOTE: If this summary of benefits conflicts in any way with your Allstate Policy, the Certificate of Coverage shall prevail.

401k

Fidelity Investments

Customer Service: (800) 835-5097

www.401k.com

- AMERISAFE will match \$0.50 for each \$1.00 of employee contribution up to 4% of pretax earnings
- Employees can defer up to 60% of pretax earnings into their 401k account (up to annual limitations)
- New enrollments, contribution election changes and beneficiary designations **MUST** be completed via the Fidelity website (www.401k.com)

REMEMBER.....



- ✓ Open Enrollment is a “negative” enrollment this year. Therefore, if you do not wish to make ***any changes*** to your current elections, you do not need to complete online enrollment (with the exception of FSA coverage which **must** be completed each year if you wish to participate in the FSA).
- ✓ If you are a new enrollee, or if you would like to make ***any*** changes to your current elections, please complete the online enrollment **no later than on November 14, 2010.**

ELIGIBILITY REQUIREMENTS FOR INSURING A CHILD

Medical Insurance

Birth through age 25:

Natural child, adopted child or stepchild, regardless of student or marital status. Exception: Dependents with access to their own employer plan/policy are not eligible.

Mentally or physically handicapped children:

Your child may be covered beyond the maximum age, provided the child is unmarried and primarily dependent upon the employee and proof of incapacity and dependency are furnished.

Dental Insurance

Birth through age 25:

Natural child, adopted child or stepchild, regardless of student or marital status. Exception: Dependents with access to their own employer plan/policy are not eligible.

Mentally or physically handicapped children:

Your child may be covered beyond the maximum age, provided the child is unmarried and primarily dependent upon the employee and proof of incapacity and dependency are furnished.

Vision Insurance

Birth through age 25:

Natural child, adopted child or stepchild, regardless of student or marital status. Exception: Dependents with access to their own employer plan/policy are not eligible.

Mentally or physically handicapped children:

Your child may be covered beyond the maximum age, provided the child is unmarried and primarily dependent upon the employee and proof of incapacity and dependency are furnished.

Flexible Spending Account (FSA)

Birth through age 26 (updated IRS regulations):

Son, daughter, stepchild, adopted child, or eligible foster child (including a child of the employee who is not the employee's dependent). Covered child does not need to qualify as a dependent for tax purposes.

Life Insurance

Birth through age 25

Natural child, adopted child or stepchild. **Must remain a full-time student and unmarried.**

*****It is your responsibility to ensure your child is eligible for coverage and to submit the appropriate documentation when requested. Coverage may be terminated retroactively if it is determined that your child is not eligible. Please contact Rebekah Fontenot at rfontenot@amerisafe.com if you need to make changes to your insurance.*****