BENEFIT PLAN

Prepared Exclusively for
Amerisafe, Inc.

Medical ET Riders

Extraterritorial Riders

Aetna Life Insurance Company

These Extraterritorial Riders are part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

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Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Alabama ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Alabama. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Alabama, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Pharmacy Benefit Limitations *(GR-9N 13-015-AL)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Alaska ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Alaska. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Alaska, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Newborn Hearing Care Screening Exam

Covered expenses include charges made for a screening test for hearing loss prior to:

- the date the newborn is discharged from the **hospital** or **birthing center**; or
- the date a child is 30 days old.

Charges for a confirmatory hearing diagnostic evaluation are a **covered expense** if the initial screening determines the child may have a hearing impairment.

Covered expenses also include charges made by a **physician,** licensed audiologist, **hospital** or **birthing center**.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- One baseline mammogram for women between the ages of 35-40;
- One routine mammogram once every two years for women between the ages of 40-50 and once each year for women age 50 and over;
- One routine Pap smear each calendar year for a female age 18 or over; and
- One routine prostate cancer screening test each year consisting of a specific antigen blood test (or any other test that is equivalent or better in cancer detection) for a male age 40 or over, or for a male age 35 through 39 who is at high risk for prostate cancer;
- 1 gynecological exam every 12 months. This includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer;
- Colorectal cancer screenings for covered persons who are:
  - 50 years of age or older; or
  - under age 50 and are at high risk for colon cancer.

The minimum colorectal cancer screening and laboratory testing will always be in accordance with the American Cancer Society's colorectal cancer screening guidelines. They currently include:

- One fecal occult blood test (FOBT) or one fecal immunochemical test (FIT) every year.
- One flexible sigmoidoscopy every 5 years.
- One digital rectal exam every 12 months.
- One double contrast barium enema (DCBE) every 5 years.
- One colonoscopy every 10 years.

The covered person, in consultation with his/her **physician** or other health care provider, will make the final decisions as to which of the above test(s) will be performed.

Alcoholism or Drug Abuse Treatment *(GR-9N 11-175-01-LA)*

Inpatient Services

The plan pays for charges made by a **hospital** or a **treatment facility** for alcoholism or drug abuse while the person is confined as an inpatient. The coverage depends on where the person is confined. If you are confined in a **hospital**, charges for the treatment of medical complications of alcoholism or drug abuse are covered. This means things such as cirrhosis of the liver, delirium tremens or hepatitis.

Inpatient Treatment Facility or Hospital

Charges for the effective treatment of alcoholism or drug abuse above are covered. If a private room is used, any charge for daily **room and board** over the private room limit will not be covered.

Limitations

- Confinement in a **treatment facility** will be covered under this Plan only as described above. It will be considered a **hospital** confinement only while benefits are paid under this section.

Outpatient Services

Charges will be paid for outpatient services and supplies furnished by a **hospital** or **treatment facility** for the treatment of alcoholism or drug abuse. This means that the person cannot be confined as a full-time inpatient in a **hospital** or **treatment facility**.

Inpatient and Outpatient Calendar Year and Lifetime Maximums.

The maximum payable per each calendar-year period is shown in the *Schedule of Benefits*. There is also a lifetime maximum that applies to all expenses incurred during any one person's lifetime for alcoholism and drug abuse treatment. The lifetime maximum is also shown in the *Schedule of Benefits*.

Important Reminder
Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Alcoholism and Drug Abuse		
Inpatient Detoxification and Rehabilitation	A percentage and **deductible** equal to the percentage and **deductible** that applies to an inpatient confinement for any other **illness**.	A percentage and **deductible** equal to the percentage and **deductible** that applies to an inpatient confinement for any other **illness**.

Maximum Benefit per day.	An amount equal to the maximum benefit per day that applies to an inpatient confinement for any other **illness**.	An amount equal to the maximum benefit per day that applies to an inpatient confinement for any other **illness**.
Maximum Amount per year period for **all** inpatient and outpatient substance abuse benefits	$16,380 - effective on and after January 1, 2008 through December 31, 2010	$16,380 - effective on and after January 1, 2008 through December 31, 2010
Maximum Benefit per lifetime for **all** inpatient and outpatient substance abuse benefits	$32,750 - effective on and after January 1, 2008 through December 31, 2010	$32,750 - effective on and after January 1, 2008 through December 31, 2010

Outpatient Treatment of Alcoholism and Drug Abuse		
Outpatient Detoxification and Rehabilitation	A percentage and a copay equal to the percentage and copay that applies to outpatient services for any other **illness**.	A percentage and a copay equal to the percentage and copay that applies to outpatient services for any other **illness**.
Maximum Amount per year for **all** inpatient and outpatient substance abuse benefits.	$16,380 - effective on and after January 1, 2008 through December 31, 2010	$16,380 - effective on and after January 1, 2008 through December 31, 2010
Maximum Benefit per lifetime for **all** inpatient and outpatient substance abuse benefits.	$32,750 - effective on and after January 1, 2008 through December 31, 2010	$32,750 - effective on and after January 1, 2008 through December 31, 2010

Important Notice:
Both **network** and **out of network** alcoholism and substance abuse treatment expenses accumulate toward any maximums shown above for alcoholism and substance abuse treatment expenses.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training/education provided by a licensed health care provider certified in diabetes self-management training;
- Medical nutrition therapy provided by a licensed health care provider certified in medical nutrition therapy; and
- Foot care to minimize the risk of infection.

Special Rules as to a Preexisting Condition *(GR-9N 28-019-01 AK)*
If you had **creditable coverage** and such coverage terminated within 90 days prior to your effective date, then any limitation as to a preexisting condition under this coverage will not apply to you.

As used above: "**creditable coverage**" means a person's prior medical coverage as defined in the Alaska Statutes 21.54.500 (7). The coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act. **Credible coverage** and **late enrollee** are defined in the Glossary.

Translation and Interpreter Services *(GR-9N 32-030-02 AK)*

You (or your authorized representative) may contact Member Services at the toll-free number on your I.D. card to receive information about the following services:

- Translation; or
- Interpreter (including audiotape or Braille).

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Arkansas ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Arkansas. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Arkansas, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Important Information

In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
1123 South University Avenue
Little Rock, AR 72204
(501) 686-2945

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Handicapped Dependent Children *(GR-9N-31-015-02 LA)*

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

At the request and expense of Aetna, proof that your child is fully handicapped must be submitted to Aetna by your Employer. In no event will this requirement preclude any eligible dependent, regardless of age. If such incapacity or dependency is removed or terminated, your Employer shall notify **Aetna**.

Continuation of Coverage for Your Former Spouse

If health coverage for the your dependent spouse would terminate due to divorce or annulment, the former spouse may continue to be covered (except for Dental Insurance). Your former spouse must have been covered for the health coverage as your dependent for at least 3 months in a row.

The person has to request continuation within 10 days of the date of the divorce or annulment.

Premium payments must be continued. Coverage will end on the earlier of the following:

- The end of 120 days after the date of the divorce or annulment.
- The date you are no longer covered under this Plan.
- The date the person becomes eligible for like coverage, including coverage for any preexisting condition, under any other group plan.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The end of the period for which contributions have been made.

Continuing Coverage after Termination of Employment
If your coverage terminates for any reason you may continue any health coverage (except Dental Insurance) in force for you and your dependents but, only if the coverage has been in force for you for at least 3 months in a row.

You have to make request in writing for this continuation. It must be done within 10 days of the date your coverage would otherwise stop. Premium payments must be made.

Coverage will stop on the earlier of:

- The end of the 120 day period which starts on the date coverage would otherwise end.
- The date you are eligible for like coverage, including coverage for any preexisting condition under any other group plan.
- The date you fail to make the required contributions.
- The date health coverage discontinues as to employees of your former Employer.

Coverage for a dependent will end when the dependent:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the group contract.

In no event will the covered amount for In-Network charges exceed more than 25% of the covered amount for Out-of-Network charges.

Treatment of Infertility *(GR-9N 11-135-01)*

Outpatient In Vitro Fertilization Expenses
Covered Expenses for outpatient in vitro fertilization procedures will be paid when they are incurred by:

- A female employee; or
- The dependent legal spouse of a male employee.

Also included are expenses incurred for cryopreservation. They will be paid on the same basis as for **illness**; but only if all these tests are met:

- The procedures are performed while the person is not confined in a **hospital** or any other facility as an inpatient.
- Her oocytes are fertilized with her husband's sperm.
- She and her husband have a history of **infertility**. It must have lasted at least 2 years; or the **infertility** is associated with one or more of these conditions:
  - Endometriosis.
  - Exposure in utero to diethylstilbestrol; known as DES.
  - Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy.
  - Abnormal male factors contributing to the **infertility**.
- She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- The in vitro fertilization procedures are performed:
  - at a medical facility licensed or certified by the Arkansas Department of Health; or certified by the Arkansas Department of Health as either.
  - meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
  - meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

Not more than the **In Vitro Fertilization Maximum** will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization or treatment from an **out-of-network provider** will not be covered. You will be responsible for full payment of the service.

Refer to the *Schedule of Benefits* for details about the maximums that apply to **infertility services**. The lifetime maximums that apply to infertility services apply differently than other lifetime maximums under the plan.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Infertility Treatment *(GR-9N-S-10-055-01)*			
Outpatient In Vitro Fertilization	Deductibles and or Copays are the same as required for any other illness. The Coinsurance is the same that is payable for any other illness.	Deductibles and or Copays are the same as required for any other illness. The Coinsurance is the same that is payable for any other illness.	Deductibles and or Copays are the same as required for any other illness. The Coinsurance is the same that is payable for any other illness.
Maximum Benefit per lifetime:	$15,000	$15,000	$15,000

Preventive Health Care Services Expenses

The charges below are included as Covered Expenses even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 19 years of age:

- A review and written record of the child's complete medical history.
- Taking measurements and blood pressure.
- Developmental and behavioral assessment.
- Vision and hearing screening.
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth;
  - Urinalysis, tuberculin test, blood tests such as hematocrit and hemoglobin tests;
  - Tests for phenylketonuria, hypothyroidism, galactosemia, sickle-cell anemia, and other genetic disorders of metabolism.
- Immunizations for infectious disease.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will only include charges incurred for Preventive Health Care Services performed at birth and at approximately each of the following ages:

2 weeks	18 months	10 years
2 months	2 years	12 years
4 months	3 years	14 years
6 months	4 years	16 years
9 months	5 years	18 years
12 months	6 years	
15 months	8 years	

Expenses incurred for vaccines and immunizations for infectious disease will not be subject to a Plan Year deductible; per visit copay/deductible; coinsurance; or maximum benefit per Plan Year.

Not covered are charges incurred:

- For services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- For services which are for diagnosis or treatment of a suspected or identified injury or disease;
- for services not performed by a physician or under his or her direct supervision;
- For medicines, drugs, appliances, equipment or supplies;
- For dental exams;
- For exams related in any way to employment;
- For pre-marital exams; or
- To the extent they are in excess of the Medicaid reimbursement level in the State of Arkansas for the same service or supply.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.
- If you are confined in a hospital, the date you are discharged from the hospital.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 60 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 60 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 60 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 60 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Mental Disorders

Covered expenses include charges made for the treatment of mental disorders.

Benefits are payable for inpatient and outpatient charges to the same extent that they are payable for any other **illness**.

Medical Foods and Low Protein Modified Foods *(GR-9N 11-156 01-AR)*

Covered expenses include charges incurred by a covered person; for non-prescription enteral formulas for which a physician has issued a written order; and are for the treatment of malabsorption caused by:

Crohn's Disease;
ulcerative colitis;
gastroesophageal reflux;
gastrointestinal motility;
chronic intestinal pseudoobstruction; and
inherited diseases of amino acids and organic acids.

Covered Expenses for inherited diseases of: amino acids; and organic acids; will also include food products modified to be low protein.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Delaware ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Delaware. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Delaware, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Scalp Hair Prosthesis *(GR-9N-11-110-01 DE)*

Coverage is provided for expenses for scalp hair prostheses worn for hair loss resulting from alopecia areata, resulting from an autoimmune disease. Coverage is subject to the same limitations and guidelines as other prostheses.

Mail Order Pharmacy Benefits *(GR-9N-13-005-01 DE)*

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Copays/Deductibles *(GR-9N-S-26-010-02 LA)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply	$15	$15
For more than a 30 day supply but less than a 61 day supply	$30	Not Applicable

Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$25	$25
For more than a 30 day supply but less than a 61 day supply	$50	Not Applicable

Non-Preferred Generic Prescription Drugs		
For each 30 day supply	$15	$15
For more than a 30 day supply but less than a 61 day supply	$30	Not Applicable

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$40	$40
For more than a 30 day supply but less than a 61 day supply	$80	Not Applicable

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Florida ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Florida. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Florida, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(GR-9N-29-010-06 FL)
An eligible dependent child includes:

- Your biological children.
- Your stepchildren.
- Your legally adopted children.
- Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court-order.
- Your grandchildren in your court-ordered custody.
- Any child whose parent is your child and your child is covered as a dependent under this Plan.
- Any other child with whom you have a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

How and When to Enroll *(GR-9N 29-015 01-FL)*

Initial Enrollment in the Plan
You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

Newborns are automatically covered for 60 days after birth. To continue coverage after 60 days, you will need to complete a change form and return it to your employer within the 60-day enrollment period.

Routine Physical Exams

Covered expenses include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children for child health supervision services from birth through age 16 also include:

- An initial **hospital** check up; and
- Well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians. Included are:
  - A review and written record of the child's complete medical history.
  - Physical Examination.
  - Developmental and behavioral assessment.
  - Anticipatory Guidance.
  - Appropriate Immunization.
  - Laboratory Test.

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Well Child Exams Includes coverage for immunizations.	Refer to the Schedule of Benefits for details on the exam copay (if applicable) and coinsurance.	Refer to the Schedule of Benefits for details on the coinsurance and deductible.	Refer to the Schedule of Benefits for details on the coinsurance and deductible.
	No Plan Year **deductible** applies.	No Plan Year **deductible** applies.	No Plan Year **deductible** applies.
Child Immunizations Only	Refer to the Schedule of Benefits for details on the exam copay (if applicable) and coinsurance.	Refer to the Schedule of Benefits for details on the coinsurance and deductible.	Refer to the Schedule of Benefits for details on the coinsurance and deductible.
	No Plan Year **deductible** applies.	No Plan Year **deductible** applies.	No Plan Year **deductible** applies.

Routine Mammograms

Covered expenses include charges incurred for routine mammograms as follows:

Routine Mammogram for women

Pregnancy Related Expenses *(GR-9N S- 11-100 01 FL)*

Covered expenses include charges made by a **physician**, nurse midwives and midwives for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Cleft Lip or Palate Treatment *(GR-9N 11-155-01 LA)*

(Dependent Children Under Age 18 only)
Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;

- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.

In no event will the covered amount for any covered service or treatment that is not available from an In-Network provider be less than 10% of the covered amount for In-Network charges.

In no event will any Out-Of Network Deductible be more than four times any In-Network Deductible. If there is no Individual In-Network Deductible, any Out-Of-Network Individual Deductible cannot exceed $500 per individual.

Extension of Benefits *(GR-9N 31-020 02 LA)*

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

In the case of maternity expense coverage, coverage will continue to be available to you for medical expenses directly relating to a pregnancy that began before coverage under this Policy ceased. Such benefits will be covered only for the period of that pregnancy.

Converting to an Individual Medical Insurance Policy *(GR-9N 31-040 01 FL)*

Eligibility

- You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan for any reason: except ceasing to contribute; or discontinued group health coverage is replaced by similar group health coverage within 31 days.

At the time of application, you will be offered a choice of at least two plans; the Standard Conversion Plan and another plan in which benefits are substantially similar to the level of benefits in a standard health benefit plan, as established pursuant to s. 627.6699(12).

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by Aetna when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.
- A lifetime maximum benefit under this plan has been reached. For example:
  - If a covered dependent reaches the group plan's lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
  - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the "Notice of Conversion Privilege and Request" form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna's** normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Georgia ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Georgia. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Georgia, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Ongoing Specialist Care: *(GR-9N-S-08-035 01 GA)*

If you have a condition which requires ongoing care from a **specialist**, you or your **physician** may request a standing **referral** to such **specialist**. Circumstances which may warrant this type of **referral** include, but are not limited to, a high risk pregnancy or dialysis treatment. You should initially make this **request** through your **PCP**. If **Aetna**, the **PCP** and/or **specialist**, in consultation with a medical director, determine that such a standing **referral** is appropriate, **Aetna** will authorize such a **referral** to a network **specialist**. **Aetna** is not required to permit you to elect to have an out-of-network **specialist**, unless such a **specialist** is not available within the network. Any authorized **referral** shall be made pursuant to a treatment plan approved by **Aetna** in consultation with the **PCP**, the **specialist** and you, or your designee.

The treatment plan may limit the number of visits or the period during which the visits are authorized and may require the **specialist** to provide the **PCP** with regular updates on the specialty care provided, as well as all necessary medical information.

When You Don't Need a PCP Referral

You don't need a **PCP** referral for:

- **Emergency care** – See *Coverage for Emergency Medical Conditions.*
- **Urgent care** – See *Coverage for Urgent Conditions.*
- **Out-of-Network Benefits** – the plan gives you the option to visit health care providers and facilities that are not in the provider network without a **referral** for **covered expenses**. You may also visit **network providers** without a **referral**. You will receive out-of-network coverage for these **covered expenses**.

- **Direct access services** – services from **network providers** for which the referral is not required. Certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the *What the Plan Covers* and *the Schedule of Benefits* sections. Refer to the *What the Plan Covers* section for information on when these benefits are covered. You can directly access these network specialists for:
  - Routine gynecologist visits;
  - Annual screening mammogram for age-eligible women;
  - Routine eye exams in accordance with the schedule.
  - Dermatology care.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

In no event will the covered amount for In-Network charges exceed more than 30% of the covered amount for Out-of-Network charges. When In-Network office visits are paid at 100% after a dollar copay, the GA Office of Insurance equates this to a 90% coinsurance when figuring the Out-of-Network coinsurance allowance. In no event will any benefit be paid at a coinsurance less than 60%.

Accessing Pharmacies and Benefits *(GR-9N-S-125-015 01 GA)*

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. These **network pharmacies** have contracted with **Aetna** to provide **prescription drugs** and other supplies to you at a **negotiated charge**. You also have the choice to access state licensed **pharmacies** outside the **network** for **covered expenses**.

Obtaining your benefits through **network pharmacies** has many advantages. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you

To better understand the choices that you have with your plan, please carefully review the following information.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**.

Pharmacy Benefit Limitations *(GR-9N 13-015-AL)*

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

Copays/Deductibles *(GR-9N-S-26-010-02 LA)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$25	$25
For more than a 30 day supply but less than a 91 day supply (mail order)	$50	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$40	$40
For more than a 30 day supply but less than a 91 day supply (mail order)	$80	Not Applicable

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	100% of the **negotiated charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

The sub-section titled 'Subrogation', if included in the 'General Provisions' section of your Booklet-Certificate, has been removed and does not apply to your plan.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Iowa ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Iowa. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Iowa, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Special Enrollment Periods *(GR-9N-29-015-03 LA)*

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Illinois ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Illinois. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Illinois, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

(GR-9N 02-005-01 IL)
WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the Group Policy's fee schedule, or recognized charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Group Policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE GROUP POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill covered persons for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the covered person other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free number on your ID card.

Routine Cancer Screenings *(GR-9N S-11-005-01 LA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- A baseline mammogram for women age 35 through age 39;
- A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under age 40 with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors;
- An annual mammogram for women age 40 and older;
- Comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a **physician**;
- An annual Pap smear;
- An annual digital rectal examination and a prostate specific antigen (PSA) test for asymptomatic men age 40 and older;

- Colorectal cancer screening, examinations, and laboratory tests incurred by a covered person age 50 and over; or of any age who is considered to be at high risk for colorectal cancer; and when prescribed by a **physician**;
- Colorectal cancer screening, examinations, and laboratory testing includes:
  - One fecal occult blood test (FOBT) every 12 months;
  - One FOBT every 12 months plus one flexible sigmoidoscopy every 5 years;
  - One digital rectal exam every 12 months;
  - One double contrast barium enema every 5 years;
  - One colonoscopy every 10 years;
  - Other approved screenings, examinations, and laboratory tests prescribed by a **physician**;
- High risk for colorectal cancer means a covered person has:
  - A personal or family history of familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial; or colon cancer or polyps;
  - Chronic inflammatory bowel disease; or
  - A background, ethnicity or lifestyle that the **physician** believes puts the covered person at elevated risk of colorectal cancer;
- Surveillance tests for ovarian cancer for women that:
  - Have a family history of at least one first-degree relative with ovarian cancer; clusters of women relatives; or nonpolyposis colorectal cancer; or
  - Test positive for BRCA1 or BRCA2 mutations;
- Surveillance tests for ovarian cancer is defined as: annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and a pelvic exam.

HPV Expense Benefit *(GR 9N S 11-20 03 IL)*

The plan pays for charges made by a **physician** for administering the human papillomavirus coverage for a human papillomavirus vaccine (HPV) that is approved for marketing by the Federal Food and Drug Administration.

Coverage is payable at the same level as any other physician expense.

Shingles Vaccine Expense Benefit *(GR 9N S 11-20 04 IL)*

The plan pays for charges made by a **physician** for administering a shingles vaccine to a member 60 years of age or older that is approved for marketing by the federal Food and Drug Administration.

Coverage is payable at the same level as any other **physician** expense.

Eosinophilic Gastrointestinal Disorder Expense *(GR-9N S-11-005-01 LA)*

Covered expenses included charges for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing **physician** has issued a written order stating that the amino acid-based elemental formula is medically necessary.

Continuing Coverage for Dependents After Your Death *(GR-9N 31-015-01 IL)*

If you should die while enrolled in this plan, your dependent's health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Additional Dependent Coverage Provision

If you should die while enrolled in this plan, your dependent child's coverage will be continued if your dependent child has reached the limiting age under the coverage or is not eligible for coverage under the spousal continuation privilege in this *Continuation of Coverage* section, upon the earliest to happen of the following:

- Failure to pay premiums when due, including any grace period;
- When coverage would terminate under the terms of the existing policy if your dependent child was still your eligible dependent;
- The date on which your dependent child first becomes, after the date of election, an insured employee under any other group health plan; or
- The expiration of 2 years from the date continuation coverage began.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Continuation of Coverage For Your Former Spouse & Retired Employee's Spouse (Spousal Continuation Privilege)

If Health Expense Coverage for your dependent spouse would terminate due to dissolution of marriage, your death or retirement, your former spouse and covered dependents may continue to be covered. For purposes of this section, the term "former spouse" includes a widow or a widower, as well as a divorced spouse. It does not include a retired employee's spouse. Your former spouse or retired employee's spouse has to apply for continuation coverage and pay the initial monthly premium within 30 days of the date your former spouse or retired employee's spouse receives the notice of the right to continue, or the right to continuation of coverage is forfeited and the continuation of benefits terminated.

Premium payments must be continued. Coverage for a former spouse under age 55 will not continue beyond the first to occur of:

- The date the former spouse becomes covered for like coverage under any group policy.
- The end of a 2 year period after the date of dissolution of marriage.
- The date coverage would have terminated if the marriage had not been dissolved. This will not apply during the first 120 days following dissolution of marriage or employee spouse's death unless the coverage would be terminated due to a change in the group contract during such 120 days.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The date the former spouse remarries.
- The end of the period for which contributions have been made.

Coverage for a former spouse and a retired employee's spouse age 55 or older will not continue beyond the first to occur of:

- The date the former spouse becomes covered for like coverage under any group policy.
- The date coverage would have terminated, except due to the retirement of an employee, if the marriage had not been dissolved. This will not apply during the first 120 days following dissolution of marriage, or employee spouse's death or retirement unless the coverage would be terminated due to a change in the group contract during such 120 days.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The date the former spouse remarries.
- The end of the period for which contributions have been made.
- The date that person reaches the qualifying age or otherwise establishes Medicare eligibility.

Upon the termination of continuation coverage, the former spouse will be entitled to convert the coverage to an individual health insurance policy.

Continuation rights granted to former spouses will include eligible covered dependents covered prior to the dissolution of marriage or the death of the employee, or the retirement of the employee for a former spouse who has attained age 55.

Payment of Benefits *(GR-9N 32-025-01 IL)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. For all health coverages, benefits will be paid within 30 days following receipt of written proof to support the claim.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Indiana ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Indiana. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Indiana, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Notice to Policyholders and Certificate Holders

Questions regarding your policy or coverage should be directed to:

Aetna Life Insurance Company
Contact Number: See your Member ID Card.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for covered females who are age 35 but less than age 40, or one mammogram every 12 months for covered females less than age 40 who are at risk;
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;

- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are **covered expenses** if you are age 50 and older, or less than age 50 and at high risk when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Diabetic Equipment, Supplies and Education *(GR-9N-11-135-01 IN)*

`**Covered expenses** include charges for the following services, supplies, equipment, as ordered by a **physician**, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Pervasive Developmental Disorder Expenses *(GR-9N-11-200-01 IN)*

Covered Medical Expenses include charges incurred by a covered person for the treatment of a pervasive developmental disorder.

Coverage is provided when treatment is prescribed by the covered person's treating **physician** in accordance with a treatment plan. Exclusions and limitations will not apply to a pervasive developmental disorder.

As used here. "pervasive developmental disorder" means a neurological condition, including Asperger's syndrome and autism, as defined it the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered Medical Expenses are payable on the same basis as any other medical condition. Lifetime maximum limits, deductibles, and coinsurance/copays may apply.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Kansas ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Kansas. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Kansas, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Coverage for Dependent Children *(GR-9N 29 010 KS)*

To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 23, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children and, as certified by you, any children placed with you for adoption;
- Your foster children;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- Routine gynecological exam;
- Routine Pap smear; and
- 1 fecal occult blood test every 12 months.

Routine Mammogram

Even though not incurred in connection with an illness or injury**, Covered Medical Expenses** include charges incurred:

- by a female for a routine mammogram.

Well Child Care

Well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services. As used here, "immunizations and booster doses of all immunizing agents" for children from birth to 72 months of age includes at least 5 doses of vaccine against diphtheria, pertussis, tetanus, 4 doses of vaccine against polio, Haemophilus B (Hib) and Hepatitis B; 2 doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella; and other vaccines and dosages as may be prescribed by the Kansas Secretary of Health and Environment.

Preexisting Conditions Exclusions and Limitations *(GR-9N 28-019-01 KS)*

A preexisting condition is an **illness** or **injury** for which, during the 90 day period immediately prior to your enrollment date medical treatment, services, or supplies were received or **prescription drug**s or medicines were taken.

The preexisting condition limitation does not apply to:

- A newborn enrolled within 31 days of birth;
- A child who is adopted or placed for adoption before attaining 18 years of age if the child becomes covered under creditable coverage within 31 days of birth, adoption, or placement of adoption;
- Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information;
- Pregnancy will not be treated as a preexisting condition.

For the first 90 days following your Enrollment Date, covered medical expenses incurred during the 90 day period immediately preceding a person's Enrollment Date for treatment of a preexisting condition include only the first $4,000 of such covered medical expenses for which no benefit is payable.

Enrollment Date means the earlier of:

- your Effective Date of Coverage under this Booklet-Certificate (or, if applicable, a prior plan of your employer that has been replaced by this Plan); or
- the first day of your probationary period, if applicable.

Special Rules as to a Preexisting Condition

If you had **creditable coverage** and such coverage terminated within 90 days prior to your effective date, then any limitation as to a preexisting condition under this coverage will not apply to you.

As used above: "**creditable coverage**" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) as of 1996. **Creditable coverage** and **late enrollee** are defined in the Glossary.

Treatment of Mental Illness and Alcoholism, Drug Abuse or Substance Use Disorders *(GR-9N 11-175 02 KS)*

Treatment of Mental Illness

Covered expenses for the treatment of a **Mental Illness** include those incurred:

- During a stay in a hospital, psychiatric hospital or residential treatment facility;
- For partial confinement treatment; and
- For outpatient treatment.

Coverage is provided under the same terms and conditions as any other illness under this Booklet-Certificate.

Remember:
Outpatient and inpatient care and **partial confinement treatment** must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Note:
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

Treatment of Alcoholism, Drug Abuse or Substance Use Disorders

Covered expenses include charges made for the treatment of **Alcoholism, Drug Abuse or Substance Use Disorders.**

Benefits are payable for charges incurred in a **hospital**, psychiatric hospital, **residential treatment facility** office for the treatment of **Alcoholism, Drug Abuse or Substance Use Disorders** as follows:

Coverage in a **hospital** includes:

- Treatment for the medical complications of **Alcoholism, Drug Abuse or Substance Use Disorders**. "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment of Alcoholism, Drug Abuse or Substance Use only when the hospital does not have a separate **residential treatment facility** section.

Partial Confinement Treatment:
Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for intermediate short-term or medically-directed intensive treatment. Such benefits are payable if your condition requires services that are only available in a partial confinement setting or if you would need inpatient care if you were not admitted to this type of facility.

Coverage is provided under the same terms and conditions as any other illness under this Booklet-Certificate.

Outpatient Treatment
This plan covers outpatient treatment of **Alcoholism, Drug Abuse or Substance Use Disorders**.

Covered expenses include charges made for outpatient treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Coverage is provided under the same terms and conditions as any other illness under this Booklet-Certificate.

Remember:
Outpatient and inpatient care and **partial confinement treatment** must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Note:
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

Mental Illness, Alcoholism, Drug Abuse or Substance Use Disorders *(GR-9N 34-065 03 KS)*

Means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American Psychiatric Association.

Continuation of Coverage After Employment Ceases

Any Health Expense Coverage then in force for you and your eligible dependents may be continued for a maximum period of 18 months after it would terminate for any reason except failure to make any required contributions; but only if:

- Premium payments for such coverage are continued;
- You have been insured for Health Expense Coverage or for Health Expense Coverage and coverage under any prior coverage for at least 3 months in a row;
- You make written request for such continuation within 31 days after the date your coverage would otherwise terminate.

Coverage will not continue for any person who is covered or eligible to be covered for Medicare or under any group plan for which he or she was not eligible prior to the date coverage would terminate.

Coverage will cease before the end of the 18 month period on the first to occur of:

- Failure to make any required contributions to your employer.
- Written mutual agreement for such cessation between you and **Aetna**.

If coverage continues for the 18 month period, the Conversion Privilege will be available at the end of such period, on the same terms as would have applied, if this section had not been included.

Coverage for a dependent may not be continued beyond the date it would otherwise terminate; exclusive of this continuation.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Kentucky ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Kentucky. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Kentucky, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

In no event will the covered amount for In-Network charges exceed more than 25% of the covered amount for Out-of-Network charges.

Routine Mammograms

Covered expenses include charges incurred for routine cancer screening as follows:

- One screening mammogram, for a person age 35 but less than 40.
- One mammogram every two years for a person age 40 but less than 50.
- One mammogram each calendar year, for a person age 50 or over.
- A mammogram for women who have been diagnosed with breast disease, upon referral by a health care practitioner acting within the scope of the practitioner's license.

Diabetic Equipment and Self-Management Education Expenses

(GR-9N 11-135-01)

Covered expenses include charges for the following expenses incurred in connection with the treatment of diabetes (including insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes):

- Equipment;
- Supplies;
- Outpatient self-management training and education (including medical nutrition therapy);
- Medications.

The treatment must be prescribed by a **physician**.

Outpatient self management education must be provided by a certified, registered or licensed provider with expertise

in diabetes.

Charges incurred for the following are not included:

- a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

Pervasive Mental Developmental Disorder (Autism) Expenses

The charges made for the services of a health care provider for rendering Pervasive Mental Developmental Disorder Services to a child who is at least 2 years of age and under 22 years of age are included as **covered expenses.**

Pervasive Mental Developmental Disorder Services means:

- therapeutic services (such as psychotherapy and speech and language therapy); and
- rehabilitative services (such as occupational and physical therapy); and
- respite services.

Not included are charges:

- for services rendered by a person who resides with you or who is part of your family; or
- for services paid for under any other part of this Plan.

Not more than the Pervasive Mental Developmental Disorder (Autism) Monthly Maximum will be payable for Pervasive Mental Developmental Disorder Services Expenses incurred by a person in any one calendar month.

Alcoholism, Substance Abuse and Mental Disorders Treatment *(GR-9N-11-170-01-LA) (GR-9N 11-175-01-LA)*

Covered expenses include charges made for the treatment of alcoholism, **substance abuse** and **mental disorders** by **behavioral health providers**.

Important Notice
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Health Plan Exclusions and Limits* section for more information.

Alcoholism and Substance Abuse *(GR-9N 11-175-01-LA)*

Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by **behavioral health providers.** In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse**.

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse**.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of alcoholism or **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital**, when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or **substance abuse**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment for Alcoholism and Substance Abuse

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**.

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

Important Reminder:
Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Alcoholism Treatment Services

The plan pays the charges of a **physician**, **hospital** or treatment facility for effective treatment of alcoholism including emergency detoxification.

For charges of a treatment facility to be covered upon completion of the phase of program of treatment by the patient under the guidance and direction of a **physician** or professional designated by a **physician**.

Coverage may be subject to the benefit limits shown in the *Summary of Benefits*.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Alcoholism and Substance Abuse			
Inpatient Treatment	90% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	80% per admission after Plan Year **deductible**

Gatekeeper PPO Medical Plan *(GR-9N S-11-005-01 LA)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	
Outpatient Treatment of Alcoholism and Substance Abuse			
Outpatient Treatment	90% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	80% per visit after Plan Year **deductible**

Treatment of Mental Disorders *(GR-9N-11-170-01-LA)*

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder:
Inpatient care must be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for more information about **precertification**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Mental Disorders			

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Mental Disorders	90% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	80% per admission after Plan Year **deductible**
Outpatient Treatment Of Mental Disorders			
Mental Disorders	90% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	80% per visit after Plan Year **deductible**

Charges made for the following are not covered:

- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care while in the custody of a governmental authority; except if the covered person is incarcerated in a local or regional jail prior to a conviction of a felony.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one Plan. "Plan" and "This Plan" are defined herein. If any provision of this section is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this section shall continue in full force and effect. The Order of Benefit Determination Rules below determines which Plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense. If you are covered by more than 1 health benefit Plan, you should file all your claims with each Plan.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;

- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts are not Plans.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.
- Is covered under any type of workers' compensation law; and
- Is not covered for that injury under such law.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Massachusetts ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Massachusetts. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Massachusetts, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French
Services d'interprétation et de traduction
Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek

Υπηρεσιες Μεταφρασεως

Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifikasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan "Aetna" gen mwayden jwenn sèvis tradiksyon nan "AT&T language line" (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ການບໍລິການນາຍພາສາແລະການແປພາສາ

ທ່ານສາມາດຕິດຕໍ່ພະແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຟຼີທີ່ປາກົດເທິງບັດປະຈຳ ໂອສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະ ລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ພະແນກບໍລິການລູກຄ້າບອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິງສຽງບໍ່ຄ່ອຍໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

ៈសេវាកម្មផ្តែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់

អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្តែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។

អ្នកជំនាញការផ្តែកសេវាកម្មនៃអតិថិជនរបស់ Aetna **មានមធ្យោបាយរកសេវាកម្មបកប្រែ**

តាមរយៈខ្សែទូរស័ព្ទភាសា AT&T **។ លេខ** TDD# **សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។**

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。**Aetna**的專業用戶服務人員使用**AT&T**語言專線 **(AT&T Language Line)** 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的**TDD**號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتا للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإدارية فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طريق خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.

(GR-9N 29-010-01)

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

When You Receive a Qualified Child Support Order *(GR-9N 29-015-01 MA)*

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, **Aetna** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Prosthetic Devices *(GR-9N 11-110-01 MA)*

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for you;
- A scalp hair prosthesis (wig) for hair loss due to treatment of any form of cancer or leukemia;
- Therapeutic/molded shoes and shoe inserts required for the treatment of or to prevent complications of diabetes.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

PPO Medical Plan *(GR-9N S10-80-01 MA)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Any coinsurance requirement for artificial limb devices to replace, in whole or in part, an arm or leg will not exceed 20%, unless such coinsurance applies to all covered benefits. With respect to Out of Network charges, any coinsurance will not exceed 40% of the cost unless such coinsurance applies to all covered benefits under the plan.		
Scalp Hair Prosthesis for Cancer or Leukemia Patients *(GR-9N-S10-95-01 MA)*	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Benefit per Plan Year	$350	$350

Clinical Trial Expenses *(GR-9N 11-210-01 MA)*

This Plan will pay for **medically necessary** and routine patient care, **physician**, and facility charges you incur when enrolled in a qualified clinical trial study.

A "qualified clinical trial" means a patient research study that meets the following criteria:

- it must be intended to treat cancer; and
- it must be peer reviewed and approved by one of the following:
  - one of the United States Institutes of Health;
  - a center or cooperative group of the National Institutes of Health;
  - a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
  - the Food and Drug Administration (FDA) pursuant to an investigational new drug exemption;
  - the Department of Defense;
  - the Department of Veterans Affairs; or
- with respect to a Phase II, III and IV clinical trial
  - a qualified institutional review board; and
  - it must be provided by a provider of health care which has the experience and training to provide the treatment in a capable manner; and
- with respect to Phase I clinical trials
  - it must be provided by an academic medical center or affiliated facility, and the providers conducting the trial shall have staff privileges at the academic medical center; and
  - you meet the patient selection criteria for participation in the qualified clinical trial; and
  - you must have signed, prior to participation in the qualified clinical trial, a statement of consent.
- available clinical or pre-clinical data provide a reasonable expectation that participation is likely to be beneficial to you; and

- it does not duplicate existing studies; and
- it must have a therapeutic intent and must assess the effect of the intervention.

Charges for **covered expenses** you incur for the treatment provided in the clinical trial are payable on the same basis as any disease or illness covered under this plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Clinical trial expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to: precertification and referral requirements.

Not covered under this plan are:

- any drug or device that is approved by the FDA, even when the off-label use of the drug or device has not been approved by the FDA for that indication, if the drug or device is paid for by the manufacturer, distributor, or provider of the drug or device; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research; and
- any expenses related to participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

Treatment of Speech, Hearing and Language Disorders *(GR-9N 11-145-01 MA)*

The plan will pay for the diagnosis and treatment by individuals licensed as speech-language pathologists or audiologists for acute speech, hearing and language disorders, but only if the services are made for:

- Diagnostic services rendered to find out if, and to what extent, your ability to speak or hear is lost or impaired;
- Rehabilitative services rendered that are expected to restore or improve your ability to speak or hear.

The treatment of speech, hearing and language disorders benefit does ***not*** cover:

- Diagnostic or rehabilitative services rendered before you become eligible for coverage or after termination of coverage;
- Special education (including lessons in sign language) to instruct you if your ability to speak or hear is lost or impaired, to function without that ability.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries;
- Hearing exams required as a condition of employment;
- Diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - that any school system, by law, must provide; or
  - as to speech therapy, to the extent such coverage is already provided for under Early Intervention Services and Home Health Care Services; or
- Any services unless they are provided in accordance with a specific treatment plan which:
  - details the treatment to be rendered and the frequency and duration of the treatment;
  - provides for ongoing services; and
  - is renewed only if such treatment is still necessary.

Early Intervention Services Expenses *(GR-9N 11SECTION020 03 MA)*

Covered expenses include early intervention services provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the **Physician** for dependents from birth until thirty six (36) months of age.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Early Intervention *(GR-9N-S-10-025-04)*	90% after the calendar year **deductible**.	70% after the calendar year **deductible**.

Preventive Health Care Services *(GR-9N 11-225-01 MA)*

The plan covers preventive health care services even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 6 years of age.

Preventive health care services are services provided for a routine exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision and hearing screening, including a newborn hearing screening test performed before the child is discharged from the **hospital** or **birthing center**;
- Lead poisoning screening;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth; and
  - Urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease; and
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered expenses will only include charges for preventive health care services performed at birth and at approximately each of the following ages:

2 months
4 months
6 months
9 months
12 months
15 months
18 months
2 years
3 years
4 years
5 years

Not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of the plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services for diagnosis or treatment of a suspected or identified injury or illness;
- Services not performed by a **physician** or under their direct supervision;
- Medicines, drugs, appliances, equipment or supplies;
- Dental exams.

Routine Cancer Screenings *(GR-9N 11-005-01 MA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram, for covered females age 35 but less than 40;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months.

Treatment of Infertility *(GR-9N 11-135-01 MA*

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of one (1) year.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-authorization by **Aetna**, subject to all the exclusions and limitations of this *Booklet-Certificate*:

- ovulation induction with menotropins; and
- intrauterine insemination.

Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- in vitro fertilization and Embryo Placement (IVF-EP);
- zygote intrafallopian transfer (ZIFT);
- gamete intra-fallopian transfer (GIFT);
- cryopreserved embryo transfers;
- intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; or ovum microsurgery

ART services are defined as: ART services, products, or procedures that are **covered expenses** under this *Booklet-Certificate*.

Infertility Case Management is defined as: A program administered by **Aetna** that consists of:

- evaluation of medical records to determine whether ART services are **medically necessary** and are reasonably likely to result in success;
- determination of whether ART services are covered benefits;
- pre-authorization for ART services by a ART Specialist when ART services are **medically necessary**, reasonably likely to result in success, and are covered benefits; and
- case management for the provision of ART services for an eligible covered person.

Eligibility for ART Benefits

To be eligible for ART benefits under this *Booklet-Certificate*, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected.
- Be referred by your **physician** to **Aetna's** infertility case management unit;
- Obtain pre-authorization from **Aetna's** infertility case management unit for ART services by an ART specialist.

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet-Certificate*:

- IVF-EP; GIFT; ZIFT; or cryopreserved embryo transfers;
- ICSI or ovum microsurgery;
- payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF-EP program, including fertilization and culture; and
- charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and bank of sperm or inseminated eggs, for ART to the extent such costs are not covered by the donor's insurer, if any.

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet-Certificate*:

- ART services for a female attempting to become pregnant who has been unable to conceive or produce conception during a period of at least 1 year prior to enrolling in the **Infertility** Program;
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits or related to the treatment of **infertility** that are not **medically necessary**;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from **Aetna's** infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**.

Important Note
Treatment of **Infertility** must be pre-authorized by **Aetna**. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment *(GR-9N S10-55-01 MA)*		
Basic and Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Advanced Reproductive Technology (ART) Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135-01 MA)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Physician Visits *(GR-9N 11-020-01 MA)*

Covered expenses also include:

- Diabetic Self-Management Education: Training designed to instruct a person in self-management of diabetes. It may also include training in self care or diet. Such charges must be made by:
  - a **physician**, nurse practitioner, clinical nurse specialist; or
  - a **pharmacy** or dietician who is legally qualified by the *Commonwealth of Massachusetts* to provide diabetic management education.
- Your diabetic equipment and self-management education services benefit does *not* cover:
  - a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
  - a general program not just for diabetics; or
  - a program made up of services not generally accepted as necessary for the management of diabetes.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.

Prescription Drug *(GR-9N 34-080-01 MA)*

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- Drugs and medicines prescribed for the treatment of cancer or HIV/AIDS even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of such indication is in one of the standard reference compendia or in medical literature. The term "standard reference compendia" means the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term "medical literature" means published scientific studies appearing in any peer-reviewed national professional journal.

Hormone Replacement Therapy *(GR-9N 11-200-01 MA)*

The plan will pay for outpatient services and supplies related to your hormone replacement therapy for peri and post menopausal women on the same basis as any other **illness**.

Contraception Services *(GR-9N 11-005-01 MA)*

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Pregnancy Related Expenses *(GR-9N 11-100-01 MA)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit be conducted by a registered nurse, **physician**, or certified nurse midwife; and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Treatment of a Biologically-Based Mental Disorder

Covered expenses include charges made by a hospital, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** (including substance abuse). Coverage shall be provided for **biologically-based mental disorders** under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical **illness**. This includes the same copayments, coinsurance, deductibles, and/or annual lifetime maximums.

Benefits are payable for the following:

- Inpatient – Inpatient services may be provided in a general **hospital** licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental **hospital** licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health;

- Intermediate services – includes charges for a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet your needs. Intermediate services include, but are not limited to, the following:

    - *Acute and other residential treatment* – Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for you while providing active treatment and reassessment.

    - *Clinically managed detoxification services* – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

    - *Partial hospitalization* – Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

    - *Intensive Outpatient Programs (IOP)* – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance abuse disorders.

    - *Day treatment* - Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance abuse disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. You do not need 24-hour hospitalization or partial hospitalization.

    - *Crisis stabilization* – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

    - *In-home therapy services* – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

The following services are not considered intermediate services:

- Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for you.

- Programs that only provide meetings or activities that are not based on individualized treatment planning.

- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.

- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. Aetna must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this Booklet-Certificate including any network requirements or co-payments/coinsurance provisions.

- Programs that provide primarily custodial care services.

- For outpatient treatment – provided in a licensed **hospital**, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of their license.

- Rape Related Mental or Emotional Disorders - Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if you are a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive that coverage provided for any other type of health care for physical **illness**.

- Children and Adolescents under the age of 19 - Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for an other health care for physical **illness**, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the **primary care physician**, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

  (1) an inability to attend school as a result of such a disorder;
  (2) the need to hospitalize the child or adolescent as a result of such a disorder;
  (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

  Aetna shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect. Please note that if COBRA or state continuation is selected, then all plan benefits will be available. If COBRA or state continuation is not selected, any premiums paid by the Policyholder to continue the mental health benefits beyond age 19 will continue health benefits only and COBRA or state continuation eligibility will not be extended.

- Psychopharmacological Services/Neuropsychological Assessment Services - Coverage shall be provided for the diagnosis and treatment of psychopharmacological services/neuropsychological assessment services under the same term and conditions and which are no less extensive than coverage provided for any other type of health care for physical **illness**.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**.
- The plan includes follow-up treatment.

If you require ongoing care from a **behavioral health provider**, you may receive a standing referral to such **behavioral health provider**. The **behavioral health provider** agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the Booklet-Certificate.

Treatment of a Non-Biologically-Based Mental Disorder

Covered expenses include charges made by a hospital, **psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the **effective treatment** of **non-biologically-based mental disorders.** Coverage will be provided for outpatient and inpatient treatment for the diagnosis and treatment of all other covered **mental disorders** subject to the maximum number of visits and days, if any shown on the *Schedule of Benefits*. In addition to meeting all other conditions for coverage, the treatment plan must include follow-up treatment.

Benefits are payable for the following:

- Inpatient – Inpatient services may be provided in a general **hospital** licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental **hospital** licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health;

- Intermediate services – includes charges for a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate services include, but are not limited to, the following:

    - *Acute and other residential treatment* – Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for you while providing active treatment and reassessment.

    - *Clinically managed detoxification services* – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

    - *Partial hospitalization* – Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

    - *Intensive Outpatient Programs (IOP)* – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance abuse disorders.

    - *Day treatment* - Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance abuse disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. You do not need 24-hour hospitalization or partial hospitalization.

    - *Crisis stabilization* – Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

- *In-home therapy services* – An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

  The following services are not considered intermediate services:

  - Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for you.
  - Programs that only provide meetings or activities that are not based on individualized treatment planning.
  - Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.
  - Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. Aetna must provide coverage for outpatient or intermediate services provided while the individual is in the program, subject to the terms of this Booklet-Certificate including any network requirements or co-payments/coinsurance provisions.
  - Programs that provide primarily custodial care services.

- For outpatient treatment – provided in a licensed **hospital**, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of their license.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**.
- The plan includes follow-up treatment.

If you require ongoing care from a **behavioral health provider**, you may receive a standing referral to such **behavioral health provider**. The **behavioral health provider** agrees to a treatment plan and provides the primary care physician with all necessary clinical and administrative information on a regular basis. The health care services provided must be consistent with the terms of the Booklet-Certificate.

Aetna may require consent to the disclosure of information regarding services for mental disorders only to the same or similar extent in which Aetna requires consent for the disclosure of information for other medical conditions.

Important Reminder

Inpatient care and partial **hospitalizations** must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Biologically-Based Mental Disorder

This means the following biologically-based mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders":

- Schizophrenia;
- Schizo-affective disorder;

- Major depressive disorder;
- Bipolar disorder;
- Paranoia and other psychotic disorders;
- Obsessive-compulsive disorder;
- Panic disorder;
- Delirium and dementia;
- Affective Disorders;
- Eating Disorders;
- Post Traumatic Stress Disorders;
- Substance Abuse Disorders;
- Pervasive developmental disorder (Autism).

Treatment is generally provided by or under the direction of a physician or mental health professional such as a psychiatrist, a psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Behavioral Health Provider *(GR-9N 34-010-01 MA)*

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorders** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists;
- Substance abuse facility licensed by the department of mental health;
- Level III community-based detoxification; acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health;
- Mental health or substance abuse clinic licensed by the department of public health;
- A public community mental health center;
- Professional office or home-based services;
- Licensed independent clinical social worker;
- Licensed mental health counselor;
- Licensed nurse mental health clinical specialist; or
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Preexisting Conditions Exclusions and Limitations *(GR-9N 28-019-01 MA)*

A preexisting condition is an **illness** or **injury** for which, during the 90 day period immediately prior to your enrollment date medical treatment, services, or supplies were received or **prescription drugs** or medicines were taken.

The preexisting condition limitation does not apply to:

- A newborn enrolled within 31 days of birth;
- A child who is adopted or placed for adoption before attaining 18 years of age if the child becomes covered under creditable coverage within 31 days of birth, adoption, or placement of adoption;

- Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information;
- Pregnancy will not be treated as a preexisting condition;
- Infertility will not be treated as a preexisting condition.

For the first 180 days following your Enrollment Date, covered medical expenses incurred during the 90 day period immediately preceding a person's Enrollment Date for treatment of a preexisting condition include only the first $4,000 of such covered medical expenses for which no benefit is payable.

Enrollment Date means the earlier of:

- your Effective Date of Coverage under this Booklet-Certificate (or, if applicable, a prior plan of your employer that has been replaced by this Plan); or
- the first day of your probationary period, if applicable.

Special Rules as to a Preexisting Condition
If you had **creditable coverage** and such coverage terminated within 90 days prior to your effective date, then any limitation as to a preexisting condition under this coverage will not apply to you.

As used above: "**creditable coverage**" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) as of 1996. **Credible coverage** and **late enrollee** are defined in the Glossary.

Thirty-One Day Continuation *(GR-9N 31-015-01 MA)*
Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to **Aetna** within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

Continuation of Coverage for Your Former Spouse
If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

Continuation of Coverage: Employment Ceases

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.
- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

Continuation of Coverage: Plant Closing

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

Continuation of Coverage for Your Dependents After Your Death

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent’s coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.

- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.

Continuing Coverage for Your Child

The terms of this Continuation of Coverage apply only to your dependent child:

- who attains the age of 19 years; and
- whose coverage under this Plan would otherwise terminate; and
- who is engaged in an ongoing treatment under this Plan, in accordance with a written treatment plan, for a mental, behavioral, or emotional disorder.

Such child's health expenses coverage, except dental expense coverage, may be continued, if:

- written request for such continuation is made within 31 days of the date coverage terminates; and
- such request includes the following:
  - an agreement to pay up to 100% of the cost to the plan; and
  - evidence, satisfactory to **Aetna,** of the existence of such a mental, behavioral, or emotional disorder.

Premium payments must be made.

Coverage will cease on the first to occur of:

- the end of a 36 month period which starts on the date coverage would otherwise terminate; or
- the date the course of treatment, as specified in the treatment plan, is completed; or
- the date the child fails to provide the required proof that the course of treatment is still ongoing; or
- the date the child is eligible for similar benefits under any group plan; or
- the date the child becomes eligible for other coverage under the Group Policy; or
- the date the child fails to make any required contributions; or
- the date health expense coverage under this Plan discontinues for employees of your employer.

Aetna will have the right to require proof of the continuation of the course of treatment. **Aetna** also has the right to examine your child as often as needed while the course of treatment continues at its own expense. An exam will not be required more often than once each year.

If any coverage being continued ceases, the child may apply for a personal policy in accordance with the *Conversion Privilege.*

Mark T. Bertolini
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Maryland ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Maryland. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Maryland, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition.

A physician is not you or related to you.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

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Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Maine. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Maine, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months or as recommended by a physician;
- 1 gynecological exam every 12 months including a rectovaginal pelvic exam for women age 25 and over who are at risk for ovarian cancer;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 50 to 72.
- colorectal cancer screening for asymptomatic individuals who are: 50 years of age or older; or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. Colorectal cancer screening means a colorectal cancer examination and laboratory test (colonoscopy) recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N-S-10-015-01)*			
Routine Mammography For covered females age 40 and over. (Coverage for Routine Mammography will be provided the same as any other Diagnostic X-Rays.)	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	80% per test No Plan Year **deductible** applies.
Prostate Specific Antigen Test For covered males age 50 to 72.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Digital Rectal Exam For covered males age 50 to 72.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Pap Smears (as required by a physician)	100% per test No Plan Year **deductible** applies.	70% per test after Plan Year **deductible**	80% per test No Plan Year **deductible** applies.

Hospice Care *(GR 9N 11 070 ME)*

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies and DME.

- Pain and symptom management;
- Nutritional counseling; and
- Counseling; Bereavement Services; and
- Respite Care

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies and DME;
  - **Pain and symptom management;**
  - Counseling;
  - Nutritional counseling.
  - Bereavement Services; and
  - Respite care

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders
Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses *(GR-9N 11-080ME*

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician or a licensed acupuncturist**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Prosthetic Devices *(GR 9N 11 110 ME)*

Covered expenses include charges made for prosthetic devices. A prosthetic device is an artificial device meant to replace, in whole or in part, an arm or a leg.

Prosthetic devices are payable at no less than on the same basis as the most current standards of Medicare. The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of an arm or a leg lost or impaired as a result of disease or injury or congenital defects. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The plan will not cover expenses and charges for, or expenses related to:

- a prosthetic device that contains a microprocessor; or
- a prosthetic device that is designed exclusively for athletic purposes; or
- prosthetic services rendered by a provider who does not contract with Aetna and prosthetic devices provided by a vendor that is not designated by Aetna.

Prosthetic devices need to be precertified by Aetna. Refer to *How the Plan Works* for details about **precertification**.

Prosthetic Devices other than artificial devices meant to replace, in whole or in part, an arm or a leg.

In addition, **covered expenses** include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee, or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the Exclusions section.

Hearing Aid Expenses *(GR-9N 11-110-020 ME)*

Covered expenses include charges for the purchase of a hearing aid for each hearing-impaired ear for an individual who is under 19 years of age.

Hearing aid means a non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

The hearing loss must be documented by a physician or audiologist licensed pursuant to Maine Title 32, chapter 77. The hearing aid must be purchased from an audiologist licensed pursuant to Maine Title 32, chapter 77 or a licensed hearing aid dealer licensed pursuant to Maine Title 32, Chapter 23-A.

Limitations:

- No benefits will be payable for a charge which is for batteries, cords and other assistive listening devices, including, but not limited to, frequency modulation systems.
- The maximum benefit payable is limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months.

Hearing Aid Expenses *(GR-9N-S-10-080-01 LA)*	90% per visit after Plan Year **deductible** For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.	70% per visit after Plan Year **deductible** For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.	80% per visit after Plan Year **deductible** For a covered person under 19 years of age: The maximum benefit payable is limited to $1,400 per hearing aid, per ear for a 36 month period.

Diabetic Equipment, Supplies and Education *(GR-9N S- 11-135-ME)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training and education services that are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control project within the Bureau of Health.
- Foot care to minimize the risk of infection.

Metabolic Formula and Special Modified Low-Protein Food Products *(GR-9N S- 11-135-ME)*

Coverage shall include metabolic formula and special low-protein food products that have been prescribed by a licensed **Physician** to treat an inborn error of metabolism. An inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. A special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

Amino Acid-Based Elemental Infant Formula *(GR-9N S- 11-137-ME)*

This Plan pays charges for amino acid-based elemental infant formula for children 2 years of age and under, regardless of the method of delivery of the formula, when a licensed **physician** has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined under Maine law, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed **physician** may be required to confirm and document ongoing **medical necessity** at least annually. **Covered expenses** will be payable the same as any other medical expense.

Such documentation includes when a licensed **physician** has diagnosed and the through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic, fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula

Metabolic Formula	90% per prescription or refill after Plan Year **deductible**	70% per prescription or refill after Plan Year **deductible**	80% per prescription or refill after Plan Year **deductible**

Medical Plan Exclusions *(GR 9N 28 025 ME)*

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under What *The Plan Covers* section or by amendment attached to this Booklet-Certificate.

Drugs, medications and supplies:
- Any services related to the dispensing, injection or application of a drug, except services related to contraception;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;

Food items: Any food item, including but not limited to infant formulas, nutritional supplements, vitamins, including but not limited to **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to Metabolic Formula and Special Modified Low Protein Food Products as specifically provided in the *What the Plan Covers* section.

Preexisting Conditions Exclusions and Limitations *(GR 9N 28 019 ME)*

A preexisting condition is an **illness** or **injury** for which, during the 6 month period immediately prior to your enrollment date:

- medical treatment, services, or supplies were received or **prescription drug**s or medicines were taken or
- medical advice, diagnosis, care or treatment was recommended or received.

The preexisting condition limitation does not apply to:

- A newborn enrolled within 31 days of birth;
- A child who is adopted or placed for adoption before attaining 18 years of age if the child becomes covered under creditable coverage within 31 days of birth, adoption, or placement of adoption;
- Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information;
- Pregnancy will not be treated as a preexisting condition.

For the first 12 months following your Enrollment Date, covered medical expenses incurred during the 6 month period immediately preceding your Enrollment Date for treatment of a preexisting condition include only the first $4,000 of such covered medical expenses for which no benefit is payable.

Enrollment Date means the earlier of:

- your Effective Date of Coverage under this Booklet-Certificate (or, if applicable, a prior plan of your employer that has been replaced by this Plan); or
- the first day of your probationary period, if applicable.

Special Rules as to a Preexisting Condition
If you had **creditable coverage** and such coverage terminated within 180 days prior to your effective date, then any limitation as to a preexisting condition under this coverage will not apply to you.

As used above: "**creditable coverage**" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) as of 1996. **Credible coverage** and **late enrollee** are defined in the Glossary.

When Coverage Ends for Employees *(GR-9N 30-005 01 ME)*

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
- Your employment stops. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, your coverage may continue until stopped by your employer as described below:
  - If you are not at work due to disease or **injury**, your employment may be continued until stopped by your employer, but not beyond 30 months from the start of the absence.
  - If you are not at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Continuing Coverage

If you:

- terminate employment due to a temporary lay-off; or
- lose employment due to an **injury** or disease that you claim to be compensable under workers' compensation;

You may continue any Health Expense Coverage (except Comprehensive Dental Expense Coverage) then in force if:

- you have been employed by your employer for at least 6 months;
- you are not eligible for Medicare;
- you are not covered for like benefits;
- you are not eligible for like benefits under any group plan;
- you are not eligible for continuation of like benefits because of any state or federal law; and
- premium payments are continued.

The coverage may be continued for you or any of your dependents who have been covered as your dependent for at least 3 months or for you and any such dependents. If a dependent has not been eligible for 3 months, the dependent must have been covered at all times while eligible.

You have to make request in writing for this continuation. This must be done within 31 days of the date coverage would otherwise cease. The request must include an agreement to pay up to 102% of the applicable group rate.

Coverage will cease on the first to occur of:

- The date you are eligible for coverage under any other group plan.
- The date you fail to make the contributions needed.
- The date the Workers' Compensation Commission determines that the disease or **injury,** that entitled the person to continued coverage, is not compensable.
- The end of a one year period which starts on the date coverage would otherwise cease.

Coverage of a dependent will cease earlier when the dependent ceases to be a defined dependent.

If any coverage being continued ceases because it has been continued for one year, the person may apply for a personal policy in accordance with the Conversion Privilege. If it ceases for any other reason, the Conversion Privilege is not available.

Continuing Coverage for Dependents After Your Death

If you should die while enrolled in this plan, your dependent's health care coverage will continue as long as:

- You were covered at the time of your death,
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- For your spouse, the date he or she remarries.

If your dependent's coverage is being continued for your dependents, a child born after your death will also be covered.

Important Note
Your dependent may be eligible to convert to a personal policy. Please see the section, *Converting to an Individual Medical Insurance Policy* for more information.

Converting to an Individual Health Insurance Policy *(GR-9N 31-040 01 ME)*

This applies if you reside in a state other than Maine. The state where you legally reside may mandate that a personal policy be offered for conversion when Medical Expense Coverage ends, no matter where the group policy may have been issued. In this case, this plan will permit certain persons whose Medical Expense Coverage has ended to convert: to a personal medical policy. No medical exam is needed. You and your family members may convert when all coverage ends because:

- of the end of your employment; or
- you cease to be in an eligible class.

But, you and your family members may not convert if: coverage ends because the group contract has been discontinued as to your medical coverage.

The personal policy may cover:

- you only; or
- you and all of your family members who are covered under this plan when your coverage ceases; or
- your family members who are covered under this plan when your coverage terminates.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this plan. If coverage for your spouse ceases due to divorce or other reason, the personal policy may cover: all your family members covered under this plan when the spouse ceases to e a dependent; or the spouse only.

You may convert when you become a retired employee. If this plan permits retired employees to continue Medical Expense Coverage, and you choose to do so, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage ceases even if the person is still eligible for benefits because the person is totally disabled.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which **Aetna** cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:
  - any other **hospital** or surgical expense insurance policy;
  - any **hospital** service or medical expense indemnity corporation subscriber contract;
  - any other group contract;
  - any statute, welfare plan or program;
- and that with the converted policy, would result in over insurance or match benefits.
- The state where you legally reside does not require conversion if the person is or could be covered under Medicare (Title XVIII of the Social Security Act, as amended).

No one has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by **Aetna** under your employer's conversion plan.

It will not provide coverage which is the same as coverage under this plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this plan after your coverage ceases.
- A statement that **Aetna** may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that **Aetna** has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert:

- Your employer should be asked for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be **Aetna's** normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this plan.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people;
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
  - Medical supplies and DME;
  - Nutritional counseling;
  - Counseling; and
  - Bereavement Services.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Missouri ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Missouri. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Missouri, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Child Health Supervision Services Expenses *(GR 9 NS 11-190)*

The charges below are included as **covered expenses** even though they are not incurred in connection with an **illness** or **injury**. They are included only for a dependent child under 13 years of age. Benefits are payable on the same basis as any other sickness.

Child Health Supervision Services Expenses are the charges for Child Health Supervision Services.

"Child Health Supervision Services" means **physician**-delivered or **physician**-supervised services which shall include coverage for services delivered at the intervals and scope stated below. Included are:

- A review and written record of the child's complete medical history.
- Physical examination.
- Developmental and behavioral assessment.
- Anticipatory guidance and education.
- Immunizations including diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization as recommended by the American Academy of Pediatrics.
- Laboratory tests.

All of the above will be in keeping with prevailing medical standards.

Covered expenses will only include charges of one physician for Child Health Supervision Services performed at birth and at approximately each of the following ages:

2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	8 years

9 months	3 years	10 years
12 months	4 years	12 years

Not covered are charges incurred for:

- services which are covered to any extent under any other part of this Plan;
- services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- services not performed by a physician or under his or her direct supervision;
- medicines, drugs, appliances, equipment, or supplies; or
- dental exams.

Routine Cancer Screenings *(GR 9 NS 11-005 MO)*

Covered expenses include charges incurred for routine cancer screening as follows:

Mammogram Expense Benefit

Covered expenses include charges incurred by covered persons for mammograms. The charges must be incurred while a covered person is insured for these benefits. Benefits are payable on the same basis as any other radiological examinations covered under this plan.

Benefits will be paid for expenses incurred for the following:

(1) A baseline mammogram for women between the ages of 35 through 39, inclusive; and
(2) A mammogram every two years; or more frequently based on the recommendation of the women's physician for women ages 40 through 49;
(3) A mammogram on an annual basis for women 50 years of age and older;
(4) A mammogram for any women, upon the recommendation of a physician, where such woman, her mother or her sister has a prior history of breast cancer.

Pelvic Examination Pap Smear Expense Benefit

Covered expenses include charges incurred by a covered person for a pelvic examination and pap smear test for cancer, for any non-symptomatic woman, in accordance with current guidelines of the American Cancer Society. Benefits are payable on the same basis as any other sickness.

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 Pap smear every 12 months; and
- 1 gynecological exam every 12 months. This includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer.

Prostate Cancer Screening Expense

Covered expenses include charges incurred by a covered person for a prostate examination and laboratory tests for any non-symptomatic man, in accordance with current guidelines of the American Cancer Society. Benefits are payable on the same basis as any other sickness.

Routine Colorectal Cancer Screening Expense

Covered expenses include charges incurred by a covered person for colorectal cancer examination and laboratory tests in accordance with the current guidelines of the American Cancer Society. Benefits are payable on the same basis as any other sickness.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Cancer Coverage – Second Opinion

Covered expenses include coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Benefits are payable on the same basis as any other sickness.

Experimental or Investigational Treatment *(GR-9N 11-195 01 MO)*

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

Covered expenses also include **Routine Patient Care Costs** as the result of a phase III or IV of a clinical trial that is approved or funded by an Official Entity and is undertaken for the purposes of the prevention, early detection or treatment of cancer.

Covered expenses also include **Routine Patient Care Costs** as the result of a phase II clinical trial undertaken for the purposes of the prevention, early detection or treatment of cancer. Phase II of a clinical trial must be sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and the patient must be enrolled in the clinical trial and not only following the protocol of a phase II clinical trial, but not actually enrolled.

The plan limits coverage for the **Routine Patient Care Costs** of patients in phase II of a clinical trial to those treating facilities within the **Aetna** benefit plans' provider network; except that, this provision shall not be construed as relieving the plan of the sufficiency of network requirements under Missouri law.

Routine Patient Care Costs for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services to administer the drug or use the device under evaluation in the clinical trial.

Routine Patient Care Costs do not include: (a) The investigational item or service itself; (b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

The treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Official Entity, for purposes of phase III and IV of a clinical trial, is one of the following entities:

1. One of the National Institutes of Health (NIH);
2. An NIH cooperative group or center - as defined by Missouri law is a formal network of facilities that collaborate on research projects and have an established NIH- approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
3. The FDA in the form of an investigational new drug application;
4. The federal Departments of Veterans' Affairs or Defense;
5. An institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
6. A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Early Intervention Services Expenses *GR 9 NS 11-005MO)*

The charges below are included as Covered Medical Expenses even though they may not be incurred in connection with an injury or disease. They are included only for: a dependent child from birth to 3 years of age, who is identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, as amended. You must submit proof of such identification with the initial claim.

Early Intervention Services Expenses
These are the charges incurred for Early Intervention Services.

Early Intervention Services
These are services, provided as part of an active individualized family service plan, that enhance functional ability without effecting cure. They include, but are not limited to, the following:

- Speech therapy given in connection with a speech impairment resulting from a congenital abnormality, disease, or injury.
- Occupational or physical therapy expected to result in significant improvement of a body function impaired by a congenital abnormality, disease, or injury.
- Assistive technology devices.

Not more than the Early Intervention Services Calendar Year Maximum will be payable for Early Intervention Services Expenses incurred by a person in any one calendar year.

Not more than the Early Intervention Services Lifetime Maximum will be payable for Early Intervention Services Expenses incurred by a person during the person's lifetime.

Early Intervention Services	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Child Early Intervention Services *(GR-9N-S-10-010-01)*			
Plan Year Maximum	$3,000	$3,000	$3,000
Aggregate Maximum over total 3 year period	$9,000	$9,000	$9,000

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Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company
Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*
Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Mississippi ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Mississippi. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Mississippi, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Jaw Joint Disorder Treatment *(GR-9N- S 11-150 MS)*

The plan covers charges made by a **physician, hospital** or **surgery center** for the diagnosis and surgical treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome or Craniomandibular Disorder; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

Benefits are payable up to the **jaw joint disorder** maximum shown in the *Schedule of Benefits*.

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a **jaw joint disorder**.

Retail Pharmacy Benefits
Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 90 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Routine Physical Exams

Covered expenses include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children:

- from birth through 24 months include the administration of appropriate and necessary immunizations and laboratory tests when given in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.
- Through age 18 also include an initial **hospital** check up and well child visit in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Payment of Benefits *(GR-9N-32-025-01MS)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim, or any portion of the claim that is clean, where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within 25 days or 35 days, whichever is applicable, after **Aetna** receives a clean claim, or any portion of the claim that is clean, containing necessary medical information and other information essential for **Aetna** to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by **Aetna** for adjudication and which requires no further information, adjustment or alteration by the provider of the services or by you in order to be processes and paid by **Aetna.** A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, **Aetna** must pay the provider (where the claim is owed to the provider) or you (where the claim is owed to you) interest on accrued benefits at the rate of 1 1/2 percent per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. In the event **Aetna** fails to pay benefits when due, you may bring action to recover such benefits, any interest which may accrue as provided in this paragraph and any other damages as may be allowable by law.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Montana ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Montana. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Montana, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Preventive Health Care Services Expenses (GR-9N 11-005 01 MT)

The charges below are included as Covered Medical Expenses even though they are not incurred in connection with an injury or disease. They are included only for a dependent child under 3 years of age.

Preventive Health Care Services

These are services provided for a routine physical exam of the child. Included are:

- A review and written record of the child's complete medical history.
- Taking measurements and blood assessment.
- Developmental and behavioral assessment.
- Vision and hearing screening.
- Other diagnostic screening tests including:
  - one series of hereditary and metabolic tests performed at birth;
  - urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease.
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered Medical Expenses will only include charges incurred for the first 10 exams.

Routine Mammogram *GR-9N-31-005-01 MT)*

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 35 or over for a routine mammogram as follows:

- One baseline mammogram, for a person age 35 but less than 40.

- One mammogram each calendar year, for a person age 40 or over.

Treatment of Inborn Errors of Metabolism (*GR-9N-31-100-01 MT)*

Covered Medical Expenses include charges incurred by a **covered person;** for the diagnosis and treatment of inborn errors of metabolism. Such conditions include but are not limited to:

- Crohn's Disease;
- ulcerative colitis;
- gastroesophageal reflux;
- gastrointestinal motility;
- chronic intestinal pseudoobstruction; and
- inherited diseases of amino acids and organic acids.

Covered Medial Expenses include diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

For the purposes of this section;

- "medical foods" means nutritional substances in any form that are;
- formulated to be consumed or administered enternally under supervision of a physician;
- specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuff or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- essential to optimize growth, health and metabolic homeostasis;
- "treatment" means licensed professional medical services under the supervision of a physician.

Benefits are payable on the basis as any other illness.

Diabetic Equipment and Self-Management Education (*GR-9N-11-135-01 MT)*

Certain expenses incurred in connection with the treatment of diabetes are Covered Medical Expenses. Benefits for these expenses are provided to the same extent as benefits for any other illness.

Hospital Expenses, Convalescent or Skilled Nursing Facility Expenses, and Home Health Care Expenses will be paid at the applicable Payment Percentage.

If a physician, nurse practitioner, or clinical nurse specialist:

- diagnoses diabetes; or
- diagnoses a significant change in the person's diabetic symptoms or condition that requires a change in the person's self -management of the disease; or
- determines that a person who is a diabetic needs reeducation or refresher education;

charges for the following will be included as Other Medical Expenses; to the extent they are not already covered under any part of this Plan:

Equipment - Charges for:

- blood glucose monitors, including monitors for the legally blind; and
- test strips for glucose monitors; and
- visual reading and urine testing strips; and

- insulin, injection aids, cartridges for the legally blind, syringes, one insulin pump each warranty period and appurtenances, insulin infusion devices, and oral agents for controlling blood sugar; and glucagons emergency kits.

Self Management Education - Charges made by:

- a physician, nurse practitioner, clinical nurse specialist; or
- a pharmacist or dietitian who is legally qualified by the State of Montana to provide diabetic management education;

for diabetic self-management education. "Diabetic self-management education" is training designed to instruct a person in the self-management of diabetes. It may include training in self care or diet. The benefit includes a $250 maximum

Charges incurred for the following are not included:

- a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
- a general program not just for diabetics; or
- a program made up of services not generally accepted as necessary for the management of diabetes.

Cost Sharing *(GR-9N-08-015-01 MT)*

Your **coinsurance** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Treatment of a Severe Mental Illness *(GR-9N-11-170-01 MT)*

Covered medical expenses for the effective treatment of a severe mental illness include those incurred:

- During a stay in a hospital or [residential] treatment facility;
- For partial confinement treatment; and•
- For outpatient treatment.

Benefits are payable in the same way as those for any other disease. Coverage under this benefit does not include treatment of a mental disorder.

Partial Confinement Treatment (GR-9N 34-080 01 MT)

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, drug abuse, **mental disorders** or **severe mental illnesses**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **[residential] treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- Day care treatment and night care treatment are considered partial confinement treatment

Severe Mental Illnesses (GR-9N 34-095 01 MT)

This means the following **severe mental illnesses** as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of **Mental Disorder**s":

- Bipolar disorder.

- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Paranoia and other psychotic disorders.
- Pervasive developmental disorder (Autism).
- Schizo-afftective disorder.
- Schizophrenia.

Treatment is generally provided by; or under the direction of; a **behavioral health provider** such as a **psychiatric physician**; a psychologist; or a psychiatric social worker.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	North Carolina ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of North Carolina. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of North Carolina, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Cancer Screenings *(GR 9N 11-005 01 NC)*

Covered expenses include charges incurred for routine cancer screening as follows:

- mammograms;
- Pap smears;
- 1 gynecological exam every 12 months (which includes surveillance tests (a transvaginal ultrasound and rectovaginal pelvic exam) for women age 25 and over who are at risk of ovarian cancer;
- 1 fecal occult blood test every 12 months; and
- digital rectal exams; and
- prostate specific antigen (PSA) tests.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk); *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Bone Density Testing *(GR-9N-11-085-01-NC)*

Bone Density testing is covered for the purpose of early detection of osteoporosis when you meet one or more of the following criteria:

a. You are estrogen deficient and at clinical risk of osteoporosis or low bone mass;
b. You have radiographic osteopenia anywhere in the skeleton;
c. You are receiving long-term glucocorticoid (steroid) therapy;
d. You have primary hyperthyroidism;
e. You are being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;

f. You have a history of low trauma bone fractures; or
g. You have another condition or are on medical therapies known to cause osteoporosis or low bone mass.

Bone mass measurement will be covered if at least 23 months has elapsed since the last bone mass measurement was performed. Coverage will be provided for follow-up bone mass measurement performed more frequently than every 23 months if **Medically Necessary**. Conditions under which more frequent bone mass measure coverage may be **Medically Necessary** include, but are not limited to:

a. Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months;
b. Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the stated date of the additional regimen.

Jaw Joint Disorder Treatment *(GR 9N S 11-150 01 NC)*

The plan covers charges made by a **physician, hospital** or **surgery center** for the diagnosis and surgical treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

Benefits are payable up to the **jaw joint disorder** maximum shown in the *Schedule of Benefits*.

Jaw Joint Disorder Treatment	90% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	80% per visit after Plan Year **deductible**

In no event will the covered amount for In-Network charges exceed more than 30% of the covered amount for Out-of-Network charges unless a copay applies to the In-Network benefit.

Retail Pharmacy Benefits *(GR 9N 13-005 01 NC)*

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 90 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits *(GR 9N 13-015 01 NC)*

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 60 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Copays/Deductibles *(GR-9N-S-26-010-02 LA)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	**NETWORK**	**OUT-OF-NETWORK**
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable

Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$25	$25
For more than a 30 day supply but less than a 91 day supply (mail order)	$50	Not Applicable

Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$40	$40
For more than a 30 day supply but less than a 91 day supply (mail order)	$80	Not Applicable

Preexisting Conditions Exclusions and Limitations *(GR-9N-28-019-01)*

A preexisting condition is an **illness** or **injury** for which, during the 90 day period immediately prior to your enrollment date medical treatment, services, or supplies were received or **prescription drugs** or medicines were taken.

The preexisting condition limitation does not apply to:

- A newborn enrolled within 31 days of birth;
- A child who is adopted or placed for adoption before attaining 18 years of age if the child or foster child becomes covered under creditable coverage within 31 days of birth, adoption, or placement of adoption or foster care;
- Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information;
- Pregnancy will not be treated as a preexisting condition.

For the first 365 days following your Enrollment Date, covered medical expenses incurred during the 90 day period immediately preceding a person's Enrollment Date for treatment of a preexisting condition include only the first $4,000 of such covered medical expenses for which no benefit is payable.

Enrollment Date means the earlier of:

- your Effective Date of Coverage under this Booklet-Certificate (or, if applicable, a prior plan of your employer that has been replaced by this Plan); or
- the first day of your probationary period, if applicable.

Special Rules as to a Preexisting Condition
If you had **creditable coverage** and such coverage terminated within 90 days prior to your effective date, then any limitation as to a preexisting condition under this coverage will not apply to you.

As used above: "**creditable coverage**" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) as of 1996. **Credible coverage** and **late enrollee** are defined in the Glossary.

Determination of Creditable Coverage
Periods of **creditable coverage** shall be established through presentation of a certificate of **creditable coverage**. You should present your certificate of **creditable coverage**, or any other evidence of your prior **creditable coverage**, as soon as possible following your enrollment; however, there is no time limit for doing so and proof of your prior **creditable coverage** will be accepted at any time.

Within a reasonable time following receipt of the certificate of **creditable coverage**, **Aetna** will make a determination regarding the amount of your **creditable coverage** and the length of any exclusion that remains.

Once a determination of **creditable coverage** has been made, **Aetna** will send you a written notice of the length of **preexisting condition** exclusion or limitation that remains after offsetting for prior **creditable coverage**. However, this notice will not be sent if the plan's **preexisting condition** exclusion or limitation is completely offset by your prior **creditable coverage**.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Nevada ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Nevada. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Nevada, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

The Department of Business and Industry, Division of Insurance of the State of Nevada provides a toll free telephone number which Nevada consumers may use for inquiries and complaints regarding health plans.

Toll Free Telephone Number: 1-888-872-3234

Hours of Operation: 8:00 AM to 5:00 PM Weekdays

Notice: The coverage provided by this certificate shall not deny a claim that involves an act of domestic violence, regardless of whether the insured contributed to any loss or injury.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

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(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Oklahoma ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Oklahoma . **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Oklahoma , and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Hearing Exam *(GR-9N 11-015OK)*

Covered expenses for covered persons 18 years of age or older include charges for an audiometric hearing exam if the exam is performed by a physician licensed to perform audiometric hearing exams.

The plan will not cover expenses for covered persons 18 years of age or older for charges for more than one hearing exam for any 24-month period.

Covered expenses for covered persons under the age of 18 include charges for services provided by a licensed audiologist and hearing aids that are prescribed, filled and dispensed by a licensed audiologist.

The **covered expense** for covered persons under the age of 18 for audiological services and hearing aids is limited to 1 for each hearing impaired ear every 48 months. The Covered Medical Expense also includes 4 additional ear molds per year for children up to 2 years of age.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **coinsurance** shown in your *Schedule of Benefits*.

In no event will the covered amount for In-Network charges exceed more than 30% of the covered amount for Out-of-Network charges unless a copay applies to the In-Network benefit.

Immunizations

Covered expenses include charges made by a **physician** for materials and the administration of the following immunizations given to children from birth to age 18: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; haemophilus influenzae type B; hepatitis A; and any other immunization subsequently required for children by the State Board of Health.

Cleft Lip or Palate Treatment *(GR-9N 11-155-01 LA)*

(Dependent Children Under Age 18 only)
Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Benefits are payable the same as any other illness.

Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Mail Order Pharmacy Benefits

Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy. Each prescription is limited to a maximum 90 day supply when filled at a network mail order pharmacy. Prescriptions for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network mail order pharmacy.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 low-dose mammography every 5 years for covered females 35 through 39 years of age;
- 1 low-dose mammogram every 12 months for covered females age 40 and over;
- 1 obstetrical/gynecological exam every 12 months;

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N-S-10-015-01)*			
Routine Mammography For covered females age 35 and over.	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	80% per test No Plan Year **deductible** applies.
Maximum Benefit per Mammography screening	Unlimited	Unlimited	Unlimited
Maximum visits for covered females age 35-39 years of age every 5 years	1 visit	1 visit	1 visit
Maximum visits per Plan Year for covered females age 40 years of age or older	1 visit	1 visit	1 visit

Pregnancy Related Expenses *GR-9N-11-100-01 OK)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

(a) 48 hours following vaginal delivery for the mother and her newly born child; or
(b) 96 hours following caesarean section for the mother and her newly born child.
- In-patient care shall include: (1) physical assessment of the mother and the newborn infant; (2) parent education, to include, but not be limited to: (a) the recommended childhood immunization schedule, (b) the importance of childhood immunizations, and (c) resources for obtaining childhood immunizations; (3) training or assistance with breast or bottle feeding; and (4) the performance of any medically necessary and appropriate clinical tests.

(c) Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center, limited to one home visit within 48 hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care.
- Postpartum care shall include: (1) physical assessment of the mother and the newborn infant; (2) parent education, to include, but not be limited to: (a) the recommended childhood immunization schedule, (b) the importance of childhood immunizations, and (c) resources for obtaining childhood immunizations; (3) training or assistance with breast or bottle feeding; and (4) the performance of any medically necessary and appropriate clinical tests. At the mother's discretion, visits may occur at the facility of the plan or the licensed health care provider.

During the initial 48 or 96 hours; no pre-certification is required for the mother or her newly born child. Pre-certification is required after the 48 or 96 hours.

Any decision to shorten such minimum inpatient coverages shall be made by the attending **physician** or certified nurse midwife that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon: a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant; b. the gestational age, birth weight and clinical condition of the newborn infant; c. the demonstrated ability of the mother to care for the newborn infant postdischarge; and d. the availability of postdischarge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery, in which case covered medical expenses include one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care, including: a. physical assessment of the mother and the newborn infant; b. parent education, to include, but not be limited to: (1) the recommended childhood immunization schedule, (2) the importance of childhood immunizations, and (3) resources for obtaining childhood immunizations; c. training or assistance with breast or bottle feeding; and d. the performance of any medically necessary and clinical tests. At the mother's discretion, such home visit may occur at the facility of the provider. In such cases; covered services shall include: home visits; parent education; and assistance and training in breast or bottle-feeding.

Recovery of Overpayments *(GR-9N 32-015 02 OK)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right will not apply more than 24 months after the overpayment was made unless: the overpayment was made due to fraud (on the part of the claimant or the health care provider); or the claimant or health care provider has otherwise agreed to return the overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse, a **mental disorder** or a **severe mental illness** condition; and
- A physician is not you or related to you.

For the purposes of Short Term Disability coverage, regular care of a physician means you are attended by a physician who:

- Is not you or related to you;
- Has the medical training and clinical expertise suitable to treat your disabling condition;
- Specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- Whose treatment is:
  - Consistent with the diagnosis of the disabling condition;
  - According to guidelines established by medical, research and rehabilitative organizations; and
  - Administered as often as needed.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: Pennsylvania ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

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- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Pennsylvania. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Pennsylvania, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Nutritional Supplements *(GR-9N-11-190-01)*

Covered Expenses include charges incurred for nutritional supplements (formulas) as **Medically Necessary** for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a **Physician**.

Nutritional Supplement Services shall be exempt from any deductible provision.

Routine Cancer Screenings *(GR-9N S-11-005-01 LA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- Routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologist; and
- 1 annual gynecological exam including pelvic examination and clinical breast exam.

Routine Pap smears and routine gynecological exams shall be exempt from any Network deductible provision.

Wellness *(GR-9N S-11-005-01 LA)*

Covered expenses include Child Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control.

Child immunizations shall be exempt from any deductible provision.

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Chairman, Chief Executive Officer and President

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(A Stock Company)

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Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder: Amerisafe, Inc.
Group Policy No.: GP-881667
Rider: South Carolina ET Medical
Issue Date: June 14, 2012
Effective Date: January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of South Carolina. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of South Carolina, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for covered females age 35 to 39
- 1 mammogram every 12 months for covered females age 40 and over
- 1 Pap smear every 12 months;
- 1 gynecological exam every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are **covered expenses** if you are age 50 and older when recommended by your **physician**:

- 1 Sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk; *or*
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Pregnancy Related Expenses *(GR-9N 11-100 01)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Cleft Lip or Palate Treatment *(GR-9N 011-155 01)*

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Coordination Of Benefits- Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable deductible, that is covered at least in part by any of the **Plan** covering the person. When a **Plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the **Plans** is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **allowable expense**. The following are examples of expenses and services that are ***not* allowable expenses**:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **Plans** provides coverage for a private room.
2. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an **allowable expense**.
4. The amount a benefit is reduced or not reimbursed by the **primary plan** because a covered person does not comply with the **Plan** provisions is not an **allowable expense**. Examples of these provisions are second surgical opinions, **precertification** of admissions, and preferred provider arrangements.
5. If all **plans** covering a person are high deductible **plans** and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible **plan's** deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one **Plan** that computes its benefit payments on the basis of reasonable or **recognized charges** and another **Plan** that provides its benefits or services on the basis of **negotiated charges**, the **primary plan**'s payment arrangements shall be the allowable expense for all the **Plans**. However, if the **secondary plan** has a negotiated fee or payment amount different from the **primary plan** and if the provider contract permits, that negotiated fee will be the **allowable expense** used by the **secondary plan** to determine benefits.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any **Plan** providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans**,** or employee benefit organization plans;

- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the **Plan** includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, Medical coverage will be coordinated with other Medical **plans**, and dental coverage will be coordinated with other dental **plans**.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan / Secondary Plan. The order of benefit determination rules state whether **This Plan** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person.

When **This Plan** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When **This Plan** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When there are more than two **Plans** covering the person, **This Plan** may be a **Primary Plan** as to one or more other **Plans**, and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

Continuing Medical Coverage *(GR-9N 31-015-02 SC)*

The following applies only if you have been covered for Medical Coverage for at least 6 months in a row.

If coverage ends, any Medical Coverage in force for you and your dependents may continue after it would otherwise terminate but only if:

- Termination is not due to non-payment of required contributions.
- The coverage is not replaced within 62 days by other group coverage.
- The group contract is still in force as to your Eligible Class.

You will be notified by your employer of your right to make application for continuation of the group policy and the amount of premium required to be paid before the start of each contract month.

Your and your dependent's coverage will end when the first of the following occurs:

- The end of a 6 month period following the end of the group contract month in which coverage would otherwise cease.
- The date you are eligible for coverage under any group plan that provides like benefits or services.
- You fail to make required contributions.
- The date the person is or could be covered by Medicare.
- Health benefits discontinue as to employees of your former Employer.

Coverage for a dependent will cease when the person:

- ceases to be a defined dependent; or
- becomes eligible for other coverage under the group contract.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Aetna Life Insurance Company

Hartford, Connecticut 06156

Extraterritorial Certificate Rider *(GR-9N-CR1)*

Policyholder:	Amerisafe, Inc.
Group Policy No.:	GP-881667
Rider:	Tennessee ET Medical
Issue Date:	June 14, 2012
Effective Date:	January 1, 2012

This certificate rider forms a part of the booklet certificate issued to you by Aetna describing the benefits provided under the policy specified above. This extraterritorial certificate-rider takes the place of any other medical extraterritorial certificate-rider issued to you on a prior date.

Note: The provisions identified herein are specifically applicable ONLY for:

- Benefit plans which have been made available to you and/or your dependents by your Employer;
- Benefit plans for which you and/or your dependents are eligible;
- Benefit plans which you have elected for you and /or your dependents;
- The benefits in this rider are specific to residents of Tennessee. **These benefits supersede any provision in your booklet certificate to the contrary unless the provisions in your certificate result in greater benefits**. You are only entitled to these benefits, if you are a resident of Tennessee, and if the benefit value exceeds those benefits covered under the group policy and booklet certificate.

Clinical Trial Expenses *(GR-9N-11-094-01 TN)*

This plan will pay for the **medically necessary** and routine patient care **physician** and facility charges incurred by a person who is enrolled in a Phase I, Phase II, Phase III or Phase IV Clinical Trial study. A "clinical trial" means a patient research study that is designed to evaluate a new drug, medical device, or service that falls within a Medicare benefit category and is not statutorily excluded from coverage. Such proposed treatment:

- must be intended to treat cancer;
- must have therapeutic intent; and
- must be recommended by the person's treating **physician** as having meaningful potential benefit to the person based upon at least two documents of medical and scientific evidence.

The clinical trial must meet the following criteria:

- It must involve a drug that is exempt under federal regulations from new drug application.
- It must be approved by centers or cooperative groups that are funded and sponsored by the National Institutes of Health, the Food and Drug Administration (FDA) in the form of an investigational new drug application, the Department of Defense, or the Department of Veterans Affairs.

Charges for **covered expenses** incurred by a person for:

- health care services for the appropriate monitoring of the person during the clinical trial; and
- the treatment;
- provided in the clinical trial; and
- that is a result of unintended medical complications caused by the treatment provided in the clinical trial;

are payable on the same basis as any illness or injury covered under this Plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including, but not limited to:

- **Aetna's** Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Covered expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to **precertification** and referral requirements.

Limitations
Unless specified above, the clinical trial benefit does ***not*** cover charges for:

- any drug, device, or service that is not approved by the FDA and that is associated with the clinical trial; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research;
- any expenses related to participation in the clinical trial, including travel, housing, and other expenses;
- any expenses incurred by a person accompanying the person; and
- any expenses related to determining eligibility for participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the person.

Off-Label Use *(GR-9N-11-110-01 TN)*

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification, step-therapy** or other **Aetna** requirements or limitations.

Recovery of Overpayments *(GR-9N-32-015-01 TN)*

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right will not apply more than 15 months as to you and 18 months as to a health care provider after the overpayment was made unless:

- the overpayment was made due to failure to provide complete information, fraud or material misstatements (on the part of you or the health care provider); or
- you or the health care provider has otherwise agreed to return the overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)