Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Policyholder: AMERISAFE, INC.

Group Policy No.: GP- 881667

This Certificate Rider describes a change in your Booklet-Certificate, which applies to group policies providing health coverage issued by Aetna Life Insurance Company in the State of Kansas. It also applies to Kansas residents covered under a group policy providing health coverage and issued by Aetna Life Insurance Company in a state other than Kansas.

The purpose of this Certificate Rider is to advise you that the **Appeals Procedure** section of your Booklet-Certificate has been revised to reflect the new Kansas mandates regarding **Claim Determination, External Review**, and **Exhaustion of Process** requirements.

Keep this Certificate Rider with your Certificate at all times.

This Certificate Rider is effective on the later of the date you become covered under the group policy and July 1, 2006.

The **Appeals Procedure** section of your Booklet-Certificate has been revised as follows:

Claim Determinations – Group Health Coverage

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the covered person within the first 15 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The covered person will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies the covered person within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a Concurrent Care Claim Extension, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a Concurrent Care Claim Extension.

Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for the covered person to file an appeal.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an Appeal if Aetna gives notice of an Adverse Benefit Determination. This Plan provides for two levels of Appeal. It will also provide an option to request an external review of the Adverse Benefit Determination.

You have 180 calendar days with respect to Group Health claims following the receipt of notice of an Adverse Benefit Determination to request your level one Appeal. Your appeal may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an Adverse Benefit Determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send in your appeal to Customer Service at the address shown on your ID Card., or call in your appeal to Customer Service using the toll-free telephone number shown on your ID Card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Level One Appeal – Group Health Claims

A level one appeal of an Adverse Benefit Determination shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an Appeal.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

Level Two Appeal (Applies Only to Group Health Claims)

If Aetna upholds an adverse benefit determination at the first level of appeal, and the reason for the adverse determination was based on medical necessity or experimental or investigational reasons, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one Appeal.

A level two Appeal of an Adverse Benefit Determination of an Urgent Care Claim shall be provided by Aetna personnel not involved in making an Adverse Benefit Determination. A level two Appeal of an Adverse Benefit Determination of a Pre-Service Claim or a Post-Service claim will be reviewed by the Aetna Appeals Committee.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 36 hours of receipt of the request for a level two Appeal.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two Appeal.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two Appeal.

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision.

External Review

An external review is an independent review by a neutral **physician** with appropriate expertise in the area at issue, of coverage denials based upon lack of medical necessity or the experimental or investigational nature of a proposed service or treatment in accordance with the external review process set forth in this Policy.

External Review Organization
An external review organization is an organization contracted with the Commissioner that selects a neutral independent **physician** with appropriate expertise in the area at issue for the purpose of performing external review.

To request an external review, the following requirements must be met:

- Coverage denials were based upon lack of medical necessity or the experimental or investigational nature of the proposed service or treatment; and
- Aetna upholds an Adverse Benefit Determination at the first level of appeal and you voluntarily waive your right to the second level of appeal; or
- You do not waive your right to a second level of appeal and Aetna upholds an Adverse Benefit Determination at the second level of appeal; or
- You have not received a final decision from Aetna within 60 calendar days of Aetna's receipt of the level two appeal, unless you requested the delay.

You, or an individual acting on your behalf (provided that you have specifically consented to or authorized such representation), who requests an External Review, must submit the External Review Request Form (except under expedited review as described in the notice), a copy Aetna's denial of coverage letter, and all other information you wish to be reviewed in support of your request. These materials must be submitted to the Kansas Insurance Department within 90 calendar days of the final Adverse Benefit Determination. You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization.

Requests for review should be submitted in writing to the address listed below. You may also contact the Department of Insurance for assistance regarding External Review at:

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612-1678
(785) 296-3071 or (800) 432-2484

The Commissioner shall make a decision on a request for external review within 10 business days after receiving all **necessary** information and notify you and your treating **physician** or health care provider acting on behalf of your, or your legally authorized designee, and Aetna in writing that a request for an External Review will or will not be granted.

The External Review Organization shall issue a written decision to you and concurrently send a copy of such decision, including the basis and rationale, to the Commissioner within 30 business days. The standard of review shall be whether the service denied by Aetna was **necessary** under the terns of your Policy. In reviews regarding experimental or investigational treatment, the standard of review shall be whether the service denied by Aetna was covered or excluded from coverage under the terms of your Policy.

The External Review Organization shall provide expedited resolution when an emergency medical condition exists and shall resolve all issues within 7 business days.

In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits.

Aetna will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

For more information about the External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Exhaustion of Process

You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you establish any litigation or administrative proceeding regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Project Rider – Kansas SB 522
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