Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Policyholder: AMERISAFE, INC.

Group Policy No.: GP-881667

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective January 1, 2007.

1. The following notice has been added to your Booklet-Certificate:

NOTICE:

Your share of the payment for health care services may be based on the agreement between your health plan and your provider. Under certain circumstances, this agreement may allow your provider to bill you for amounts up to the providers' regular billed charges.

2. The following has been added to the first page of your Booklet-Certificate entitled "**Your Group Coverage Plan**" and the first page of your **Summary of Coverage**:

Type of
Accident & Health Coverage: Medical (PPO) Expense Insurance

The following have been added to the **Comprehensive Coverage** section of your Booklet-Certificate:

Anesthesia and Associated Hospitalization For Certain Dental Care

Covered Medical Expenses include charges made for general anesthesia and associated **hospital** charges in connection with dental care if the person, as determined by the treating **dentist**, has a mental or physical condition which requires that the dental treatment be rendered in a **hospital** setting.

Such determination must be in accordance with the utilization standards of the "Indications for General Anesthesia" as published in the reference manual of the American Academy of Pediatric Dentistry.

Benefits are payable on the same basis as any other disease or injury. No other charges incurred in connection with the dental procedure will be paid unless specifically provided for under this Plan.

Not included are charges:
incurred for the treatment of temporomandibular joint dysfunction; and
for any service or supply furnished by an anesthesia provider who is not an educationally qualified specialist in pediatric dentistry or other dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Outpatient Surgical Expenses

Charges made:

- in its own behalf by:
  a **surgery center**; or
  the outpatient department of a **hospital**.
- by a **physician**;

for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a **hospital**. The procedure must meet these tests:

- It is not expected to:
  result in extensive blood loss;
  require major or prolonged invasion of a body cavity; or
  involve any major blood vessels.
- It can safely and adequately be performed only in a **surgery center** or in a **hospital**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies

These are:

- Services and supplies furnished by the **surgery center** or by a **hospital** on the day of the procedure.
- Services of the operating **physician** for performing the procedure and for:
  related pre and postoperative care; and
  the administering of an anesthetic.
- Services of any other **physician** for the administering of an anesthetic. This does not include a local anesthetic.

Comprehensive Coverage section (continued)

Limitations

No benefit is paid for charges incurred:

- For the services of a **physician** who renders technical assistance to the operating **physician**.
- While the person is confined as a full-time inpatient in a **hospital**.

Benefits are payable on the same basis as “Hospital Expenses” under the plan.

Routine Screening for Colorectal Cancer

Even though not incurred in connection with a disease or **injury**, Covered Medical Expenses include charges incurred by a covered person, for colorectal cancer screening and laboratory testing, as described below.

Colorectal cancer screening and laboratory testing includes:

- A fecal occult blood test;
- A flexible sigmoidoscopy; or
- A colonoscopy;

in accordance age, family history and frequency guidelines set forth in the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society.

Benefits will be paid on the same basis as any other applicable expense under this Plan.

Diabetic Equipment, Supplies and Self-Management Education

Covered Medical Expenses include charges made by:

- a **physician**; or
- a certified, registered, or licensed health care professional with expertise in diabetes management to whom the person has been referred by a **physician**;

for diabetic self-management education.

“Diabetic self-management education” is a training program in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy. It includes the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

Coverage is provided for one initial evaluation and training program per person per lifetime.

If the person’s attending **physician** determines that a significant change in the person’s symptoms or medical condition has occurred, this Plan will pay for additional training programs.

A "significant change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

Covered Medical Expenses also include the equipment and supplies **necessary** for the treatment of diabetes.

Comprehensive Coverage section (continued)

Benefits will be paid on the same basis as any other applicable expense under this Plan.

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.

Clinical Trial Expenses

This Plan will pay for the **necessary** and charges incurred by a covered person, who is enrolled in a Phase II, Phase III or Phase IV Clinical Trial study, for routine patient care, physician and facility expenses. A "clinical trial" means a patient research study that is designed to evaluate a new medical or drug treatment. Such proposed treatment:

- is being provided with a therapeutic or palliative intent for patients with cancer or for the prevention or early detection of cancer;
- must have clinical and pre-clinical data that: shows the clinical trial is medically indicated; and will likely be more effective for that patient than available non-investigational alternatives; and
- as to experimental or investigational technologies, is likely to be beneficial to the covered person, based upon at least two documents of medical and scientific evidence.

A "qualified clinical trial" must meet the following criteria:

- It must be peer reviewed, and approved by: centers or cooperative groups that are funded and sponsored by:
  the United States National Institutes of Health (NIH);

  the Food and Drug Administration (FDA);

  the Department of Defense;

  the Department of Veterans;

  the National Cancer Institute (NCI);

  a federally funded general clinical research center; or

  other similar national cooperative body.

- It must have a written protocol and have been approved by all relevant Institutional Review Boards (IRB) before persons are enrolled. **Aetna** reserves the right to request documentation to confirm that the clinical trial meets current standards for scientific merit; and has the relevant IRB approval.

A "qualified" IRB must meet the following criteria:

- Meets all the federal requirements for the operation of institutional review board as identified in the Code of Federal Regulation;
- Is not disqualified to oversee clinical research by the NIH or the FDA for noncompliance with federal law; and
- Has taken corrective action to rectify any noncompliance issue raised by the NIH or FDA within the past 3 years; and has passed all subsequent NIH or FDA inspections, audit or examinations

Clinical Trial Expenses (continued)

- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training; and treat a sufficient volume of patients to maintain that experience;
- Trial participation must meet the patient selection criteria enunciated in the study protocol;
- Consent for participation in the trial is provided in a manner that is consistent with current legal and ethical standards;
- It does not unjustifiably duplicate existing studies; and
- It must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

For clinical trials involving experimental or investigational technologies (i.e. drugs, devices and procedures), the treatment or clinical trial must meet all of the following requirements:

- the investigational drug; device, therapy; or procedure; is under current review by the FDA and has an Investigational New Drug number (this does not apply if the investigational study is not required to be conducted under FDA scrutiny); and
- the clinical trial has passed independent scientific scrutiny and has also been approved by an IRB that will oversee the investigation; and
- the clinical trial is sponsored by a national cooperative body (ex. Department of Defense) and conforms to the oversight criteria as defined by that organization for the performance of clinical trials; and
- the clinical trial is not a single institution or investigator study (this does not apply to NCI designated Cancer Center Trials).

Charges for Covered Medical Expenses incurred by a covered person for 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;

will be paid on the same basis as any other applicable expense under this Plan.

Any care provided in the clinical trial must be for services that are considered Covered Medical 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 persons 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 are:

- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any services to clinical trial participants needed solely to satisfy data collection needs of the clinical trial (ex. protocol-induced costs); and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

Hearing Aid Expenses for Children

This Plan pays charges for prescribed hearing aids and hearing aid expenses for children under the age of 18.

Hearing aid means:

- any wearable, non-disposable instrument or devise designed to aid or compensate for impaired human hearing; and
- parts; attachments or accessories.

Covered Medical Expenses include the following:

- charges for an audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:

  a Physician certified as an otolaryngologist or otologist; or

  an audiologist who either:

  is legally qualified in audiology; or

  holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and

  who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- charges for electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam;
- any other related services necessary to access, select and adjust or fit a hearing aid.

Covered hearing aid expenses will not include, during any one period of 36 consecutive months:

- charges for more than one hearing aid per ear; and
- charges in excess of the $1,400 Hearing Aid Per Ear Maximum.

If a higher priced hearing aid is installed, covered hearing care expenses will not exceed the reasonable charges for a conventional hearing aid of similar capability.

Benefits will be paid on the same basis as any other applicable expense under this Plan. However, expenses incurred for the purchase of hearing aids will be paid up to the Hearing Aid Per Ear Maximum.

Limitations:

No benefits are payable under this benefit for charges incurred for:

- a service or supply which is received while the person is not a covered under this Plan;
- replacement of:

  a hearing aid that is lost, stolen or broken; or

  a hearing aid installed within the prior 36 month period;
- replacement parts or repairs for a hearing aid;
- batteries or cords;
- a hearing aid that does not meet the specifications prescribed for correction of hearing loss;
- any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist;

- any hearing aid furnished or ordered because of a hearing exam that was done before the date the person became covered under this Plan;

Hearing Aid Expenses for Children (continued)

- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your **Employer**;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any hearing exam:

  required by an **employer** as a condition of employment;

  which an **employer** is required to provide under a labor agreement; or

  which is required by any law of government.

Benefits After Termination of Coverage

This section applies only if a person's coverage terminates while the person is not "totally disabled" as defined in the Health Expense Benefits After Termination section.

Expenses incurred for hearing care within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if:

the **prescription** for the hearing aid was written; and

the hearing aid was ordered;

during the 30 days before the date coverage ends.

Treatment of Attention Deficit/Hyperactivity Disorder

Included as Covered Medical Expenses are charges for outpatient services and supplies made by a **physician**, **hospital** or other licensed health care provider that are **necessary** to diagnose and treat a person with Attention Deficit/Hyperactivity Disorder (ADHD).

ADHD is a syndrome of disordered learning and disruptive behavior, that is not caused by any serious underlying physical or mental disorder, but which is characterized:

- primarily by inattentiveness; or
- primarily by hyperactivity and impulsive behavior; or
- by the signficant expression of both.

A person diagnosed with ADHD has experienced symptoms of the disorder in multiple social settings (home, school, workplace, etc.) for a period of 6 months or more and to a degree that is maladaptive and inconsistent with developmental level.

ADHD outpatient services and supplies include, but are not limited to,:
- a medical evaluation including diagnostic labwork and testing;
- pharmacological treatment;
- psychosocial treatment; and
- other services and supplies received from a **physician, hospital** or other licensed health care provider.

Treatment of Attention Deficit/Hyperactivity Disorder (continued)
Not included are charges for services or supplies that are paid under any other part of this Plan. Benefits will be paid on the same basis as any other applicable expense under this Plan.

Reconstructive Breast Surgery

Covered Medical Expenses include reconstruction of the breast on which the mastectomy is performed, including an implant and areolar reconstruction.

Also included is:
- surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy; and
- A breast implant after a mastectomy.

Benefits will be paid on the same basis as any other applicable expense under this Plan.

Dietary Food Formulas For The Treatment of Certain Inherited Metabolic Diseases

Covered Medical Expenses include charges for non-**prescription** low protein food products for home use, as required by written order (**prescription**) of a **physician**, that are **necessary** for the treatment of certain inherited metabolic diseases. This means diseases caused by an inherited abnormality of body chemistry and is limited to the following diseases:
- glutaric acidemia;
- isovaleric acidemia;
- maple syrup urine disease;
- methylmalonic acidemia;
- phenylketonuria;
- propionic acidemia;
- tyrosinemia; and
- urea cycle defects.

Benefits will be paid on the same basis as any other applicable expense under this Plan. “Low protein food products” are those specially formulated to have less than one gram of protein. They do not include natural foods that are naturally low in protein.

Limitations
Unless specified above, the dietary food formula benefit does ***not*** cover charges for dietary food formulas to the extent such benefits are payable elsewhere under this Plan.

3. The following has been added to the "**Other Medical Expenses**" provision in the **Comprehensive Coverage** section of your Booklet-Certificate:

   This plan pays for the following charges:
   - those made by a **physician** for telemedicine in accordance with any applicable state or federal law;
   - those made by a qualified interpreter/transliterator, who is not a family member, for translation services used by the covered person in connection with covered medical treatment or diagnostic consultations performed by a **physician**, provided the services are required because of a hearing impairment of the person or a failure of the person to understand or otherwise communicate in spoken

   Other Medical Expenses (continued)

   - language;
   - those incurred for bone density measurements; and
   - those incurred by professional ambulance service to transport a a **newly born infant** and **temporarily medically disabled mother** from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

4. The exclusion appearing in the **General Exclusions** section of your Booklet-Certificate that applies to "expenses for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational" has been revised. The following exception, which applies to expermimental or investigational drugs, replaces the similar text appearing in the exclusion:

   Also, this exclusion will not apply with respect to drugs that:

   have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

   are being studied at Phase II or higher level in a national clinical trial sponsored by the National Cancer Institute;

   if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

   Please refer to the benefit *"Clinical Trial Expenses"* for additional coverage information.

5. The exclusion appearing in the **General Exclusions** section of your Booklet-Certificate that applies to expenses that are "for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays" has been revised to add the following:

   This exclusion does not apply to charges incurred for the diagnosis and **necessary** treatment of Attention Deficit/Hyperactivity Disorder.

6. The exclusion appearing in the **General Exclusions** section of your Booklet-Certificate that applies to expenses "that a covered person is not legally obligated to pay" has been revised to add the following:

   This exclusion does not apply to charges made by facilities owned or operated by the State of Louisiana or any of its political divisions.

7. The exclusion appearing in the **General Exclusions** section of your Booklet-Certificate that applies to expenses incurred for "plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons" has been revised to add the following:

   This exclusion will not apply to the extent such services or supplies are provided under the *Reconstructive Breast Surgery* benefit.

8. The definition of "Plan" in the **Coordination of Benefits** provision in your Booklet-Certificate has been replaced with the following definition:

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

   A. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
   B. Other group prepaid coverage under service plan contracts, or under group or individual practice;
   C. Uninsured arrangements of group or group-type coverage;
   D. Labor-management trusteed plans, labor organization plans, **employer** organization plans, or **employee** benefit organization plans;
   E. Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
   F. Medicare or other governmental benefits;
   G. 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.

9. The description of a person's "eligibility for Medicare" appearing in the **Effect of Medicare** provision in your Booklet-Certificate has been replaced with the following description:

   A person is "eligible for Medicare" if he or she is covered under it or, with respect to Part B of Medicare:

   - is covered under it; or
   - is not covered under it because of:

   having refused it;

   having dropped it;

   having failed to make proper request for it.

10. The following has been added to the **Termination of Coverage** provision of your Booklet-Certificate:

    If your Health Expense Benefits Coverage under this Plan terminates, you should contact the Louisiana Health Insurance Association for information concerning the Louisiana Health Plan.

As to your Health Expense Benefits Coverage, except as may otherwise be provided in this Booklet-Certificate, **Aetna** shall not be liable for benefits accrued, or for expenses incurred for services rendered, subsequent to the termination date if termination results from a failure of your **Employer** to pay premiums or where your coverage is terminated due to your failure to maintain eligibility as provided in this Plan.

11. The following provisions have been added to the **General Information Concerning Your Coverage** section of your Booklet-Certificate:

Continuation of Coverage During a Military Leave of Absence

Your and your dependents' coverage will be continued during a military leave of absence, providing that you meet the following requirements:

- the leave is approved by your **Employer**;
- written request for continuation of coverage under this plan is approved by
- **Aetna**; and

Continuation of Coverage During a Military Leave of Absence (continued)

- premium continues to be paid.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your **Employer** determines your approved Leave of Absence is terminated.
- The date the coverage involved discontinues as to your eligible class.
- The date the Group Policy terminates.

Reinstatement of Coverage Due to a Military Leave of Absence

If coverage for you or your covered dependent's terminates due to a military leave of absence, you or your covered dependents may again become covered in accordance with the terms of this Plan provided that coverage is requested from the **Employer** within 31 days of your return to active work, or in the case of a dependent, within 31 days of returning from active service in the military.

Any Limitation as to a pre-existing condition will apply only to the extent it would have applied if coverage had not terminated. Also, any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

Continuity of Care

In the event a covered person has started a course of treatment for a health condition and his or her **Preferred Care Provider** is voluntarily or involuntarily terminated from participating in the plan, Aetna will notify a covered person at least 30 days before the effective date of the termination.

A covered person may continue the course of treatment with the **Preferred Care Provider** although he or she has been terminated from participating in the plan, but only in the following circumstances:

- The covered person has been diagnosed as a high risk pregnancy or is past the 24th week of pregnancy. Coverage will be continued through delivery and postpartum care related to the pregnancy and delivery.
- The covered person has been diagnosed with a life-threatening illness. Coverage will be continued until the course of treatment has been completed but will not exceed 3 months from the effective date of the termination.

A life-threatening illness means a severe, serious or acute condition for which death is probable.

The availability of coverage is subject to the following:

- all of the terms and conditions of the Policy; and
- the **Preferred Care Provider** has agreed to abide by all of the terms and conditions of the provider agreement (between Aetna and the provider) that was in effect prior to the effective date of the termination. Such terms and conditions include, but are not limited to: compensation, quality assurance and utilization management standards, and any other rules, policies, and procedures.

Limitations:

This provision does not apply:

- to terminations that are due to:
  -quality-related reasons;
  -fraud;
  -suspencion, revocation or applicable restriction of the health care provider's license to practice by a state government agency;
- if the covered person:

Continuity of Care (continued)

  -moves out of the geographic **service area** of the Plan;
  -chooses to change health care provider; or
  -requires only routine monitoring for a chronic condition but is not in an acute phase of the health condition;
- if the **Preferred Care Provider**:
  -moves out of the geographic service area of the Plan; or
  -does not consent to continue to provide services to the covered person.

Notice of Claim-Claim Forms

You must furnish notice of claim to **Aetna**. This must be done within 20 days after any loss covered by the group contract, occurs or starts. If you fail to give notice within the required time, a claim will not be invalidated or reduced if such notice is furnished as soon as reasonably possible.

Aetna will furnish you with claim forms within 15 days of the notice of claim. Your **employer** also has claim forms. If forms are not furnished, you will be deemed to have met all of this Plan's proof of loss requirements.

12. The following provision replaces the same provision currently appearing in the **General Information Concerning Your Coverage** section of your Booklet-Certificate:

Subrogation and Right of Reimbursement

As used herein, the term "Third Party", means any party that is, or may be, or is claimed to be responsible for injuries or illness to a covered person. Such injuries or illness are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party injuries.

If this Plan pays benefits under this booklet-certificate to a covered person for expenses incurred due to Third Party Injuries, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this Plan on behalf of the covered person that are associated with the Third Party Injuries. **Aetna**'s rights of recovery apply to any recoveries made by, or on behalf of, the covered person from the following sources including, but not limited to:

- payments made by a Third Party or any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any Workers' Compensation or disability award or settlement;
- medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate a covered person for injuries resulting from an **accident** or alleged negligence.

By accepting benefits under this Plan, the covered person specifically acknowledges **Aetna**'s right of subrogation. When this Plan pays health care benefits for expenses incurred due to Third Party Injuries, **Aetna** shall be subrogated to the covered person's right of recovery against any party to the extent of the full cost of all benefits provided by this Plan. **Aetna** may proceed against
any party with or without the covered person's consent.

By accepting benefits under this Plan, the covered person also specifically acknowledges **Aetna**'s right of reimbursement. This right of reimbursement attaches when this Plan has paid health care benefits for expenses incurred due to

Subrogation and Right of Reimbursement (continued)

Third Party Injuries and the covered person or the covered person's representative has recovered any amounts from a Third Party. By providing any benefit under this Certificate, **Aetna** is granted an assignment of the proceeds of any settlement,

judgment or other payment received by the covered person to the extent of the full cost of all benefits provided by this Plan. **Aetna**'s right of reimbursement is cumulative with and not exclusive of **Aetna**'s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this Plan, the covered person or the covered person's representatives further agree to:

A. Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by the covered person.

B. Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**'s rights of subrogation and reimbursement under this booklet-certificate.

C. Give **Aetna** a lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).

D. Pay from any recovery, settlement judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with Third Party Injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing.

E. Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan.

F. Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of Third Party Injuries.

After a covered person has been made whole, as defined by any applicable law, **Aetna** may recover against the excess funds the full cost of all benefits paid by this Plan under this booklet-certificate without regard to any claim of fault on the part of the covered person, whether by comparative negligence or otherwise. **Aetna** will pay its proportionate share of the covered person's attorney's fees or other costs associated with the covered person's claim or lawsuit, to the extent that Aetna recovers any portion of the benefits paid under this policy pursuant to its right of subrogation or reimbursement. In the event the covered person or the covered person's representative fails to cooperate with **Aetna**, the covered person shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

13. The following has been added to the **Reporting of Claims** provision of your Booklet-Certificate:

You may also contact Aetna to obtain claim forms.

14. The following has been added to the **Payment of Benefits** provision of your Booklet-Certificate:

Benefits will be payable not more than 30 days after receipt of proof.

15. The following definitions replace the same definitions appearing in the **Glossary** section of your Booklet-Certificate:

Emergency Condition

This means a recent and severe medical condition. This includes, but is not limited to, severe pain. Such medical condition would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition; sickness; or **injury**; is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

A medical condition will be considered an emergency condition based upon whichever one of the following is most favorable to the covered person:

- the presenting symptoms; or
- the final diagnosis of the medical condition;

as they are reported to Aetna by the hospital emergency room provider.

Physician
This means a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

16. The following definitions replace the same definitions appearing in the **Glossary** section of your Booklet-Certificate:

Non-Occupational Disease
As to medical coverage, a "non-occupational" disease is a disease that does not:
- arise out of, or in the course of, any activity in connection with:
  -employment; or
  -self-employment;

  whether or not on a full time basis; and
- result, in any way, from a disease or **injury,** which arises out of such activity.

If proof is furnished to Aetna that a person under the workers' compensation law (or other like law):
- has made claim under such law in connection with a distinct disease; and
- no benefit, award, settlement or redemption has been or will be made under that law for such disease;

that disease will be considered non-occupational.

Non-Occupational Disease (continued)

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
As to medical coverage, 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.

If proof is furnished to Aetna that a person under the workers' compensation law (or other like law):
- has made claim under such law in connection with a distinct **injury**; and
- no benefit, award, settlement or redemption has been or will be made under that law for such **injury**;

that **injury** will be considered non-occupational.

An **injury** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- is covered under any type of workers' compensation law; and
- is not covered for that **injury** under such law.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a service, supply or **prescription drug** covered under this Plan.

Prescription
An order of a **prescriber** for a service, supply or **prescription drug** covered

under this Plan. If it is an oral order for a supply or **prescription drug**, it must promptly be put in writing by the **pharmacy**.

17. The following definitions have been added to the **Glossary** section of your Booklet-Certificate:

Aetna
This means Aetna Life Insurance Company.

Employee
This means any person employed by an **employer**.

Employer
This means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an **employee** benefit plan; and includes a group or association of employers acting for an employer in such capacity.

Newly Born Infant
This means a child from the time of birth until age one month or until such time as the infant is well enough to be discharged from a hospital or neonatal special care unit to his home, whichever period is longer.

Temporarily Medically Disabled Mother
This means a woman who has recently given birth and whose physician has advised that normal travel would be hazardous to her health.

18. The following "**Dependents**" eligibility provision replaces the same eligibility provision appearing in your **Summary of Coverage**:

Dependents
You may cover your:
- wife or husband; and
- unmarried children who are under 21 years of age.]

Any other unmarried child under age 24 who:

- goes to school on a regular basis and depends solely on you for support; or
- in the opinion of a qualified psychiatrist, is unable attend school on a full-time basis and hold self-sustaining employment due to a mental or nervous condition, problem or disorder;

will be covered as a dependent.

Your children include:
- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any child placed in your home due to the execution of an act of voluntary surrender.

- Any child:
  whose parent is your child; and

  who depends primarily on you for support or for whom you have legal custody; and

  who becomes covered within 31 days of birth, or the date you obtain legal custody, and remains continuously covered.
- Any other child you support who lives with you in a parent-child relationship.

19. The following has been added to the **Special Enrollment Periods** provision appearing in your **Summary of Coverage**:

    Your newly acquired dependents through the execution of an act of voluntary surrender will not be considered to be **Late Enrollees**. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the execution of an act of voluntary surrender.

    Coverage will be effective in the case of the execution of an act of voluntary surrender of a child, on the date the act of voluntary surrender becomes irrevocable.

20. The following provision replaces the same provision appearing in your **Summary of Coverage**:

    ## Special Rules Which Apply to an Adopted Child

    Any provision in this Plan that limits coverage as to a preexisting condition; will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date:
    - the child is "placed for adoption" in your home (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation

    Special Rules Which Apply to an Adopted Child (continued)

    - of adoption of the child); or
    - the child is placed in your home due to the execution of an act of voluntary surrender and it becomes irrevocable;

    provided that such placement takes effect after the date your coverage becomes effective; and you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption or the act of voluntary surrender becomes irrevocable.

Coverage for the child will become effective on the date the child is placed with you for adoption or the act of voluntary surrender becomes irrevocable. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan and will only become effective if evidence of his or her good health, acceptable to Aetna, is given to Aetna.

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

Rider: Louisiana Revisions
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