

SERFF Tracking Number: ICCI-125694877 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 39298
Company Tracking Number: MNL AE 1206
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: MNL AE 1206
Project Name/Number: MNL AE 1206/MNL AE 1206

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: MNL AE 1206	SERFF Tr Num: ICCI-125694877	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 39298
Sub-TOI: H16G.001A Any Size Group - PPO	Co Tr Num: MNL AE 1206	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Brenda Dawson	Disposition Date: 06/13/2008
	Date Submitted: 06/13/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: MNL AE 1206	Status of Filing in Domicile: Not Filed
Project Number: MNL AE 1206	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 06/13/2008	
State Status Changed: 06/13/2008	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	
See attached cover letter and endorsement	

Company and Contact

Filing Contact Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com

SERFF Tracking Number: ICCI-125694877 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 39298
Company Tracking Number: MNLAE 1206
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: MNLAE 1206
Project Name/Number: MNLAE 1206/MNLAE 1206

519 Colman Center Drive (815) 316-6714 [Phone]
Rockford, IL 61108 (815) 316-6720[FAX]

Filing Company Information

Madison National Life Insurance Company, Inc. CoCode: 65781 State of Domicile: Wisconsin
P. O. Box 5008 Group Code: Company Type:
Madison, WI 53705 Group Name: State ID Number:
(800) 356-9601 ext. [Phone] FEIN Number: 39-0990296

SERFF Tracking Number: ICCI-125694877 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company, Inc.	\$20.00	06/13/2008	20841487

SERFF Tracking Number: ICCI-125694877 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/13/2008	06/13/2008

SERFF Tracking Number: ICCI-125694877 State: Arkansas
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Disposition

Disposition Date: 06/13/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	MNL Authorization Letter	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Supporting Document	Fee schedule	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: MNL AE 1206

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MNL AE 1206	Certificate Amendment	Amendatory Endorsement, Insert Page, Endorsement or Rider	Initial		50	MNL AE 1206 rev 12-26-06.pdf

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

P.O. Box 5008, Madison, WI 53705

AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this Amendatory Endorsement is attached is amended as follows:

[A. **Schedule of Benefits** – under the section entitled “**Medical Deductible Per Calendar Year**” the following changes are hereby made:

a. The text “Failure to Pre-Certify specified Prescription Medications” is deleted and replaced with the following:

Failure to Pre-Determine specified Prescription Medications – No coverage for specified medication

[b. The following is added under this section:

[Failure to Pre-Determine Non-Emergency Care Ambulance Transportation Services – [No coverage for the ambulance service]]

[Failure to Pre-Determine Durable Medical Equipment in excess of [\$1,000] – [No coverage for the durable medical equipment.]]]

[B]. **SECTION 2 – ELIGIBILITY FOR INSURANCE AND EFFECTIVE DATE OF COVERAGE** – subparagraph **E. Late Enrollee Eligibility {Employee or Dependent}** – the second paragraph pertaining to the Effective Date of coverage for Late Enrollees is deleted in its entirety and replaced with the following:

For Late Enrollees, the Effective Date of coverage under the Policy will be the first date of the month next following the date on which We receive and approve the Enrollment Form. Pre-Existing Conditions will not be covered until the Late Enrollee is continuously covered under the Policy for a period of 18 months following the Late Enrollee’s Effective Date.

[C]. **SECTION 3 – BENEFITS** – Subparagraph **A – Major Medical Benefits**, the following changes are hereby made:

[1.] [Item [8] pertaining to Medical services and supplies, subparagraph i. pertaining to the rental of Durable Medical Equipment is amended by adding the following at the end of the subparagraph:

Pre-Determination is required for Durable Medical Equipment that exceeds \$[1000].]

[2.] Item [10] pertaining to Screening services, [subparagraph b. item 1)] pertaining to cervical cytologic screening is deleted in its entirety and replaced with the following:

1) One cervical smear or pap smear for the early detection of cervical cancer and endometrial cancer per Calendar Year [and the Physician’s office visit in connection with the cervical or pap smear]. Examination and laboratory tests, which means conventional pap smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

[3.] Item [10] pertaining to Screening services, the following benefit is added:

d. Colorectal cancer examinations and laboratory tests for colorectal cancer for Insured Persons who are 50 years of age or older, or less than fifty (50) years of age and at high risk for colorectal cancer according to the most current American Cancer Society colorectal cancer screening guidelines.

A person may be at high risk for colorectal cancer if they have any of the following colorectal cancer risk factors:

- a personal history of colorectal cancer or adenomatous polyps;
- a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative {parent, sibling, or child} younger than 60 or in 2 first-degree relatives of any age);
- a personal history of chronic inflammatory bowel disease;
- a family history of an hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer)

The colorectal cancer screening and examination, includes the following:

- (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test; and
- (ii) Flexible sigmoidoscopy every five years; or
- (iii) Double contrast barium enema every five years; or
- (iv) Colonoscopy every ten years.

[This benefit is not subject to the [In-Network] [Calendar Year Deductible] [Copayment] [and] [Coinsurance].] [If the Insured Person uses an Out-of-Network Provider, the Out-of-Network Deductible and Coinsurance requirements apply.] Additional screenings needed for the Medically Necessary treatment of a covered Sickness will be considered under the Policy as a Covered Charge and benefits are payable on the same basis as other covered diagnostic tests.

[[4. The following benefit is added:

- [12.] Medical treatment, services and supplies received in a Retail Health Clinic for the treatment of a covered Sickness or Injury. [Covered Charges are [not] subject to the [Deductibles] [Co-payments] [and] [or] [Coinsurance] requirements.] [Covered Charges are subject to the [[In Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified in the Schedule Benefits.] [Covered Charges will be paid at the In-Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge].]

[D]. **[SECTION 3 – BENEFITS – Subparagraph B – Limited Major Medical Benefits**, the following benefit[s] [are] [is] hereby added:

- [9.] [Electronic Consultations for non-urgent medical care, provided such Electronic Consultations are provided for the Medically Necessary treatment of a covered Sickness or Injury and in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the Electronic Consultation is rendered. [Covered Charges are subject to the [[In Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified in the Schedule Benefits.] [Covered Charges will be paid [at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge]] [up to a maximum benefit of [\$35] per Electronic Consultation [and a maximum of [3] Electronic Consultations per [calendar week] [day]] per Insured Person].]

To be considered a Covered Charge, Electronic Consultations must meet all of the following conditions:

1. The Insured Person is currently a patient of and under the care of the Physician rendering the Electronic Consultation;
2. The Physician provides online medical evaluation and management service in response to the Insured Person's request; and
3. The Physician maintains all documentation related to the Electronic Consultation in the Insured Person's medical file, including:
 - a. written documentation of the Insured Person's condition and symptoms;
 - b. the Physician's diagnosis and plan of treatment; and
 - c. the name and dosage of any medications prescribed.

The following are not Covered Charges under this benefit:

1. Urgent medical needs or urgent message responses;
2. Appointment scheduling, cancellations or rescheduling, or reminders of scheduled office visit appointments;
3. Refilling, renewing or transferring existing prescriptions;
4. Scheduling of diagnostic tests or the reporting of normal test results; or
5. Providing counseling, instructional or educational training or materials.]

- [10.] [Telephone medical consultation with a [In-Network] Physician for non-emergency health care, provided such consultation is provided for the Medically Necessary treatment of a covered Sickness or Injury. [Benefits are subject to a [\$35] telephone consultation fee per consultation.] [Benefits are subject to the [[In-Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified on the Schedule of Benefits.] [Benefits are payable up to a maximum benefit of [\$35] per consultation [and a maximum of [3] consultations per [calendar week] [day] per Insured Person].]]

[To be considered a Covered Charge, telephone medical consultations must meet all of the following conditions:

1. The Insured Person is currently a patient of and under the care of the Physician rendering the telephone medical consultation; and
2. The Physician maintains all documentation related to the telephone consultation in the Insured Person's medical file, including:
 - a. written documentation of the Insured Person's condition and symptoms;
 - b. the Physician's diagnosis and plan of treatment; and
 - c. the name and dosage of any medications prescribed.]

[The following are not Covered Charges under this benefit:

1. Urgent medical needs or urgent message responses;
2. Appointment scheduling, cancellations or rescheduling, or reminders of scheduled office visit appointments;
3. Refilling, renewing or transferring existing prescriptions;
4. Scheduling of diagnostic tests or the reporting of normal test results; or
5. Providing counseling, instructional or educational training or materials.]

[E.] SECTION 4 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE – the following change[s] [is] [are] hereby made:

[a.] Item #1 pertaining to a Pre-Existing Condition is deleted in its entirety and replaced with the following:

1. A Pre-Existing Condition, until a continuous period of (a) twelve (12) months has elapsed from the Enrollment Date for other than Late Enrollees and (b) 18 months has elapsed from the Effective Date with respect to Late Enrollees. This paragraph does not apply to a newborn or newly adopted child or child placed for adoption under the age of 18 if such child is enrolled for coverage within 31 days from the date of birth or the date of adoption or placement for adoption. We will credit the time the Insured Person was covered by a plan of Creditable Coverage against this Pre-existing Condition exclusion period if no more than 63 days elapsed between the termination of the Insured Person's prior Creditable Coverage and the Insured Person's Enrollment Date or, the Late Enrollee's Effective Date; or

[b. Item #[57] pertaining to telephone consultations is deleted in its entirety and replaced with the following:

- [57.] Missed appointment fees, fees for completing claim forms, fees related to obtaining hospital Pre-Certification, and fees related to the provision of medical records; or]

[F.] **SECTION 5 – ACCESSING AND ADMINISTERING YOUR BENEFITS** – the following changes are hereby made:

1. Under Subparagraph **A – Managed Care**, the provision entitled “Pre-Certification Program,” the following changes are hereby made:

- a. The first paragraph pertaining to Pre-Certification as applicable to Inpatient Confinements and certain Prescription Drug Orders is deleted in its entirety and replaced with the following:

The Pre-Certification Program is applicable to all Inpatient Confinements. An additional Deductible Amount per Hospital Confinement is specified in the Schedule of Benefits (Applicable to Covered Charges incurred in connection with an Inpatient Confinement when the Insured Person does **NOT** comply with the Pre-Certification. If the Insured Person complies with the Pre-Certification, the additional Deductible will not apply.)

- b. The third paragraph pertaining to the Policy’s Pre-Certification requirements is deleted in its entirety and replaced with the following:

The Policy requires Pre-Certification by an Insured Person of all proposed Inpatient Confinements in a Hospital, as defined by the Policy for more than 23 hours.

2. Under Subparagraph **A – Managed Care**, the provision entitled “Medications Subject to Pre-Certification Program” is deleted in its entirety and replaced with the following:

Pre-Determination of [Non Emergency Care Ambulance Transportation Services,] [Durable Medical Equipment that exceeds \$[1000]] [and] Certain Prescription Drugs

Pre-Determination is required in order to receive any benefits for the Charges listed below. The Insured Person is responsible for assuring that the required Pre-Determination is received before the Charges are incurred by calling the designated Pre-Determination service. Failure to comply with the Pre-Determination requirement will result in no benefits being paid and no coverage for such Charges.

The Insured Person must obtain Pre-Determination for the following Charges. **If the Insured Person does not obtain Pre-Determination, Charges incurred for the following are not Covered Charges:**

- [1.] [Non-Emergency Care licensed professional Ambulance transportation services to transport an Insured Person to a Facility or from a Facility to another Facility.]
- [2.] [Durable Medical Equipment as provided in Section 4 A. Major Medical Benefits, subparagraph [8i] herein that exceeds \$[1000].]
- [3.] The following Prescription Medications:
 - a. Specialty Medications including, but not limited to, growth hormones, insulin, chemotherapy immunosuppressants; *provided however*, injectible antibiotics, vitamins, allergen desensitizing agents, vaccines and local anesthetics do not require Pre-Determination.
 - b. Immunosuppressants;
 - c. AZT, Retrovir, Zidovudine or any HIV antiretroviral medication;
 - d. “Off Label” use, Orphan Drugs and Investigative New Drugs (IND);
 - e. Group “C” Cancer Drugs (drugs for specific types of tumors that have specified to have beneficial effect, but are awaiting FDA approval);

Pre-Determination of the above described Prescription Medications is required [only if the [Optional] Prescription Medication Benefit Rider is specified as applicable on the Schedule of Benefits.] [The Prescription Medications listed in sub-paragraph 3 above are covered only if the [Optional] Prescription Medication Benefit Rider is specified as applicable in the Schedule of Benefits and the Pre-Determination requirement has been met.]]

3. Under Subparagraph **B – Provider Networks**, the following changes are hereby made:
- a. The fifth paragraph pertaining to treatment, services and supplies an Insured Person receives outside the In-Network service area while traveling is deleted in its entirety and replaced with the following:

When an Insured Person receives treatment, services or supplies outside the In Network service area for a Sickness or Injury with symptoms which arise suddenly and require immediate care and treatment while traveling out of the In Network service area for business or vacation, Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such treatment, services or supplies were not pre-arranged or pre-scheduled prior to the Insured Person's trip and were received or purchased within the United States.

- [b. The following paragraphs are added:

When an Insured Dependent Child is a full-time student actively attending an accredited college, vocational or high school outside the In Network service area [for more than [ninety (90)] days], Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such Charges were received or purchased within the United States.

[When an Insured Dependent Child lives apart from You and resides outside the In Network service area [for more than [ninety (90)] days], Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such Charges were received or purchased within the United States.]]

4. Under Subparagraph **C – Pre-existing Conditions Limitation**, item #2 pertaining to Insured Persons who are Late Enrollees is deleted in its entirety and replaced with the following:
2. For Insured Persons who enroll outside an Initial Enrollment Period or Special Enrollment Period (Late Enrollees), Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 18 months after the Effective Date. A Pregnancy will not be considered a Pre-Existing Condition; and

[G.] SECTION [9] – DEFINITIONS

1. The following definitions are hereby added:

Bundling. Inclusion of related Charges for room, supplies and other Charges for goods, services and medications as recognized by industry standards including, but not limited to National Correct Coding Initiative, Packaging and Bundling Rules, Current Procedure Terminology, Outpatient Prospective Payment System, Complete Global Service Data for Orthopedic Surgery, Relative Value for Physicians, and Diagnosis Related Grouping as being included in the Charge for the primary medical procedure or room Charge. "**Unbundling**" or "**Unbundled Charges**" occurs when a Physician or a Facility separates some of the Charges that should be included in the "global" bundle charge for room, surgical, operation of other Charges which results in duplication of Charges.

[Electronic Consultations: The practice, by a Physician of health care delivery, diagnosis, consultation, treatment, by means of the Internet or similar electronic communications, that does not require a face-to-face encounter with the patient for all or any part of the Electronic Consultation.

The term includes online medical evaluations, online visits and terms with similar web-based nomenclature.]

Pre-Certification. A screening process to determine if the proposed Inpatient Hospital Confinement and treatment plan are Medically Necessary. Pre-Certification is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.

[Pre-Determination/Pre-Determine. A screening process to determine if the proposed services, drugs or supplies are Medically Necessary. Pre-Determination is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.]

[Retail Health Clinics. A medical clinic located in a retail setting that offers medical services on a non-Emergency or Urgent Care basis and meets all of the following conditions:

- a. It has a well-defined and limited scope of clinical services;
- b. Clinical services and treatment plans must be evidenced-based and quality improvement-oriented;
- c. It must have a formal connection with physician practices in the local community, to provide continuity of care;
- d. It must be duly licensed by the state or regulatory agency responsible for such licensing in the state in which the Clinic is located; [and]
- e. [Other health professionals, such as nurse practitioners, can only operate in accordance with state and local regulations, as part of a “team-based” approach to health care and under responsible supervision of a practicing, licensed physician;] [and]
- f. It must have a referral system to physician practices or to other appropriate entities when the patient’s symptoms exceed the clinic’s scope of services; [and]
- g. [It uses an electronic health record systems compatible with the continuity of care record supported by the American Academy of Family Physicians that can communicate the patient’s information with the family physician’s offices].

The term shall also apply to an institution which otherwise meets the required conditions, referring to itself as a convenience clinic or any such other facility. A Retail Health Clinic does not include: Ambulatory Surgical Centers, Urgent Care Facility, or any other such Facility.]

2. The definition “Specialty Medications” is deleted in its entirety and replaced with the following:

Specialty Medications. Prescription Medications that may be administered by a Physician as an Outpatient or self-administered in a home setting and are listed on the Specialty Drug List maintained by Us or Our designee, as revised from time to time at Our discretion.

3. The definition “Usual, Reasonable and Customary” is deleted in its entirety and replaced with the following:

Usual, Reasonable and Customary. Charges for services and supplies, which are the lesser of: (a) the Charge usually made for the service or supply by the Physician or Facility who furnished it; (b) the negotiated rate; and; (c) the reasonable Charge as determined by Us made for the same service or supply in the same geographic area.

We shall determine to what extent the Charge is reasonable, taking into account: (a) The complexity involved; (b) The degree of professional skill involved; (c) Data compiled and regularly updated from Our records or those of Our agents. We use and subscribe to a standard industry reference source that collects data for determining excessive fees and makes it available to its member companies. The data base used reflects the amounts Charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice annually. The data is reflective of reported provider Charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base. We then use a specific representative percentile of that range of Charges; (d) The condition being treated; (e) Any medical complications or unusual circumstances; (f) The amounts the Physician or Facility routinely accepts as full payment from all payers after good faith collection efforts; and (g) other pertinent factors.

The Physician's or Facility's usual Charge must not exceed the usual Charge made by most providers of like service in the same geographic area. Area means the geographical area as determined by Us which is significant enough to establish a representative base of Charges for the treatment.

The following are examples of Charges that will not be considered Usual, Reasonable and Customary: (1) Pharmaceutical charges which exceed 200% of Average Wholesale Price or cost, which ever is less; (2) Unbundled Charges; and (3) Charges which industry standards recognize as included in the primary charge. When it is determined by this specific payment methodology that a Charge by a Physician or Facility is above the Usual, Reasonable and Customary amount, the Charge is not a Covered Charge.

4. The definition "Utilization Review" is amended as follows:

Item #3 pertaining to "Certification," the term is deleted and replaced with "Pre-Certification."

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] whichever is later] [the Effective Date as specified by an attached Endorsement.]

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.



Larry Graber
President



Adam Vandervoort
Secretary

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 06/13/2008
Comments:
Attachment:
 Cert of Comp 19 MNL AE 1206.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 06/13/2008
Bypass Reason: Application MNL EEAPP 0205 previously approved on June 30, 2005
Comments:

Satisfied -Name: MNL Authorization Letter **Review Status:** Approved-Closed 06/13/2008
Comments:
Attachment:
 ICC Authorization letter Madison Nat 2008.pdf

Satisfied -Name: Cover letter **Review Status:** Approved-Closed 06/13/2008
Comments:
Attachment:
 AR MNL AE 1206 6-13-08.pdf

Satisfied -Name: Fee schedule **Review Status:** Approved-Closed 06/13/2008
Comments:
Attachment:
 AR_Fee_Schedule MNL AE 1206 6-13-08.pdf

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s): MNL AE 1206

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Larry R. Graber

Name

President

Title

June 13, 2008

Date



Madison National Life

January 1, 2008

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
519 Colman Center Dr.
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Madison National Life Insurance Company, Inc. regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Madison National may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in cursive script that reads "Larry R. Graber". The signature is written in black ink and is positioned above the printed name.

Larry Graber



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

June 13, 2008

Honorable Julie Benafield Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: MADISON NATIONAL LIFE INSURANCE COMPANY, INC. - NAIC# 65781
FEIN# 39-0990296
Amendatory Endorsement – MNL AE 1206

Dear Commissioner Benafield Bowman:

Enclosed for review and approval for use in your state is the above referenced form. This form is new and is not intended to replace any form previously approved by your Department. This form is intended to be used with Group Major Medical Expense Policy form MNL MMP 0205 previously approved by your Department on June 30, 2005.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Madison National Life Insurance Company, Inc. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

This Amendatory Endorsement will revise Certificate form MNL MMC 0205, also previously approved by your Department on June 30, 2005, by adding and/or revising certain definitions; for Late Enrollees revising the 9 month waiting period and 9 month exclusion period for Pre-Existing Conditions to 18 months; adding certain benefits; and revising some managed care provisions.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

These documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the non-variable text of the forms or to the general print size.

Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815)316-6720, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.



ARKANSAS INSURANCE DEPARTMENT

1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Madison National Life Insurance Company Inc.
Company NAIC Code: 65781
Company Contact Person & Telephone #: Brenda Dawson, Insurance Compliance Consultants, Inc., (815) 316-6714
Form Number(s): MNL AE 1206

* INSURANCE DEPARTMENT USE ONLY *
* ANALYST: AMOUNT: ROUTE SLIP: *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing * x \$50 = **Retaliatory

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. * x \$50 = **Retaliatory

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. *1 x \$20 = \$20 **Retaliatory

Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. * x \$20 = **Retaliatory

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. * x \$25 = **Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to * x \$400 =

amend an Insurer's Certificate of Authority.

Filing to amend Certificate of Authority.

*** _____ x \$100 = _____

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.