

SERFF Tracking Number: IADC-126566448 State: Arkansas
Filing Company: Madison National Life Insurance Company Inc State Tracking Number: 45348
Company Tracking Number: MNL SMGRP HEARING AID RIDER
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
Product Name: Act 1179 Compliance - Hearing Aids
Project Name/Number: /

Filing at a Glance

Company: Madison National Life Insurance Company Inc

Product Name: Act 1179 Compliance - Hearing Aids SERFF Tr Num: IADC-126566448 State: Arkansas

Aids

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 45348
Closed

Sub-TOI: H16G.003A Small Group Only - PPO Co Tr Num: MNL SMGRP State Status: Approved-Closed
HEARING AID RIDER

Filing Type: Form

Author: Shellie Howard

Date Submitted: 04/02/2010

Reviewer(s): Rosalind Minor

Disposition Date: 05/19/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/19/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Employer, Association

Explanation for Other Group Market Type:

State Status Changed: 05/19/2010

Created By: Shellie Howard

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Shellie Howard

PPACA: Pre-PPACA Submission

Filing Description:

Hearing aid benefit rider to comply with Act 1179 and bulletin 7A-2009. Please see cover letter for additional details.

Company and Contact

Filing Contact Information

Shellie Howard, Forms Development &

howards@iacusa.com

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Compliance Specialist
 2101 W. Peoria Ave 602-861-6070 [Phone]
 Suite 100
 Phoenix, AZ 85029-4925

Filing Company Information

Madison National Life Insurance Company Inc CoCode: 65781 State of Domicile: Wisconsin
 1241 John Q Hammons Drive Group Code: 450 Company Type: Life and Health
 Madison, WI 53717 Group Name: State ID Number:
 (608) 830-2000 ext. [Phone] FEIN Number: 39-0990296

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: \$20 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company Inc	\$20.00	04/02/2010	35346086
Madison National Life Insurance Company Inc	\$280.00	05/17/2010	36594272

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/19/2010	05/19/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/17/2010	05/17/2010	Shellie Howard	05/17/2010	05/17/2010
Pending Industry Response	Rosalind Minor	05/12/2010	05/12/2010	Shellie Howard	05/17/2010	05/17/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Fees	Note To Filer	Rosalind Minor	04/05/2010	04/05/2010

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Disposition

Disposition Date: 05/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document (revised)	Application	Approved-Closed	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Certificate of Compliance	Approved-Closed	Yes
Form	[Optional] Hearing Aid Rider	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Indemnity Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Policyholder Election Form	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/17/2010

Submitted Date 05/17/2010

Respond By Date

Dear Shellie Howard,

This will acknowledge receipt of the captioned filing.

Objection 1

- Schedule of Benefits, MNL MMC SD SB 0510 AR (Form)
- Schedule of Benefits, MNL MMC PPO SB 0510 AR (Form)
- Indemnity Schedule of Benefits, MNL MMC IND SB 0510 AR (Form)
- Schedule of Benefits, MNL MMC DD SB 0510 AR (Form)

Comment:

Before approval is given to your submission, I need written certification that benefits paid to a PPO and Non-PPO will comply with our Bulletin 9-85 which states in part that there will be no more than a 25% differential in payment to a PPO and Non-PPO.

Thank you.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/17/2010
Submitted Date 05/17/2010

Dear Rosalind Minor,

Comments:

Please see response below.

Response 1

Comments: Please find AR certificate of compliance per the State's requirement. We certify that there will be no more than a 25% differential in payment to a PPO and a Non-PPO.

Related Objection 1

Applies To:

- Schedule of Benefits, MNL MMC SD SB 0510 AR (Form)
- Schedule of Benefits, MNL MMC PPO SB 0510 AR (Form)
- Indemnity Schedule of Benefits, MNL MMC IND SB 0510 AR (Form)
- Schedule of Benefits, MNL MMC DD SB 0510 AR (Form)

Comment:

Before approval is given to your submission, I need written certification that benefits paid to a PPO and Non-PPO will comply with our Bulletin 9-85 which states in part that there will be no more than a 25% differential in payment to a PPO and Non-PPO.

Thank you.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certificate of Compliance

Comment:

No Form Schedule items changed.

SERFF Tracking Number: IADC-126566448 *State:* Arkansas
Filing Company: Madison National Life Insurance Company Inc *State Tracking Number:* 45348
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TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.003A Small Group Only - PPO
Product Name: Act 1179 Compliance - Hearing Aids
Project Name/Number: /

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing.

Sincerely,
Shellie Howard

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Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/12/2010
Submitted Date 05/12/2010
Respond By Date 05/19/2010

Dear Shellie Howard,

This will acknowledge receipt of the captioned filing.

Objection 1

- [Optional] Hearing Aid Rider, MNL MMC HEARDAIDAE AR 0310 (Form)

Comment:

On 4/5/10, I sent a Note to Filer that we needed an additional filing fee in the amount of \$30.00.

If the additional fee is not received by 5/19/10, the filing will be disapproved.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 05/17/2010
 Submitted Date 05/17/2010

Dear Rosalind Minor,

Comments:

Please find response below

Response 1

Comments: I have added an extra \$280 in filing fees, as I needed to update this filing to include the policyholder election form, as well as updated Schedules to include the mandates for invitro fertilization and medical foods. They were not included on the prior filed schedule, however, were included on the Amendatory Endorsement approved prior. The application is not being resubmitted, it is referenced only as a recent approval.

Related Objection 1

Applies To:

- [Optional] Hearing Aid Rider, MNL MMC HEARDAIDAE AR 0310 (Form)

Comment:

On 4/5/10, I sent a Note to Filer that we needed an additional filing fee in the amount of \$30.00.

If the additional fee is not received by 5/19/10, the filing will be disapproved.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment: Application forms approved under SERFF Tracking #ICCI-126586569 approved May 12, 2010.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Schedule of Benefits	MNL MMC SD SB		Schedule Pages	Revised	Paper Filing		MNL MMC SD SB

SERFF Tracking Number:	IADC-126566448	State:	Arkansas	
Filing Company:	Madison National Life Insurance Company Inc	State Tracking Number:	45348	
Company Tracking Number:	MNL SMGRP HEARING AID RIDER			
TOI:	H16G Group Health - Major Medical	Sub-TOI:	H16G.003A Small Group Only - PPO	
Product Name:	Act 1179 Compliance - Hearing Aids			
Project Name/Number:	/			
	0510 AR		approved 06/30/05 0510 AR (HSA) SOB (for filing) 051910.pdf	
Schedule of Benefits	MNL MMC PPO SB 0510 AR	Schedule Pages	Revised Paper Filing approved 6/30/05	MNL MMC PPO SB 0510 AR (PPO) SOB (for filing) 051910.pdf
Indemnity Schedule of Benefits	MNL MMC IND SB 0510 AR	Schedule Pages	Revised Paper Filing app 06/30/05	MNL MMC IND SB 0510 AR(Indem nity) SOB (for filing) 051910.pdf
Schedule of Benefits	MNL MMC DD SB 0510 AR	Schedule Pages	Revised paper filing app June 30, 2005	MNL MMC DD SB 0510 AR (Daily Ded) SOB (for filing) 051910.pdf
Policyholder Election Form	MNL AEAR OPT ELC AR 0510	Other	Initial	MNL AEAR OPT ELC AR 0510 for filing 051910.pdf

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Product Name: Act 1179 Compliance - Hearing Aids
Project Name/Number: /

f

No Rate/Rule Schedule items changed.

Thank you Rosalind for you continued review of this filing, and I apologize for the delay.

Sincerely,
Shellie Howard

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Project Name/Number: /

Note To Filer

Created By:

Rosalind Minor on 04/05/2010 09:29 AM

Last Edited By:

Rosalind Minor

Submitted On:

05/19/2010 12:57 PM

Subject:

Additional Fees

Comments:

Our Rule 57 on filing fees has recently been updated. Please review the General Instructions for ArkansasLH.

The new filing fee for this submission is \$50.00. Please send an additional \$30.00.

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Form Schedule

Lead Form Number: MNL MMC HEARDAE AR 0310

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/19/2010	MNL MMC HEARDAE E AR 0310	Certificate	[Optional] Hearing Aid Rider	Initial			MNL MMC HEARDAE AR 0310 (Optional Hearing Aid Rider)033010.pdf
Approved-Closed 05/19/2010	MNL MMC SD SB 0510 AR	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: MNL MMC SD SB 0205 Previous Filing #: Paper Filing approved 06/30/05		MNL MMC SD SB 0510 AR (HSA) SOB (for filing) 051910.pdf
Approved-Closed 05/19/2010	MNL MMC PPO SB 0510 AR	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: MNL MMC PPO SB 0205 Previous Filing #: Paper Filing approved 6/30/05		MNL MMC PPO SB 0510 AR (PPO) SOB (for filing) 051910.pdf
Approved-Closed 05/19/2010	MNL MMC IND SB 0510 AR	Schedule Pages	Indemnity Schedule of Benefits	Revised	Replaced Form #: MNL MMC IND SB 0205 Previous Filing #: Paper Filing approved 06/30/05		MNL MMC IND SB 0510 AR (Indemnity) SOB (for filing) 051910.pdf
Approved-Closed 05/19/2010	MNL MMC DD SB 0510 AR	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: MNL MMC DD SB 0205 Previous Filing #: Paper filing app June		MNL MMC DD SB 0510 AR (Daily Ded) SOB (for filing)

SERFF Tracking Number: IADC-126566448 State: Arkansas
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TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
Product Name: Act 1179 Compliance - Hearing Aids
Project Name/Number: /

30, 2005

Approved- MNL AEAR Other Policyholder Election Initial
Closed OPT ELC Form
05/19/2010 AR 0510

051910.pdf
MNL AEAR
OPT ELC AR
0510 for filing
051910.pdf

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

**[OPTIONAL] HEARING AID BENEFIT RIDER
FOR ARKANSAS RESIDENTS ONLY**

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

If You are covered under the [optional] Hearing Aid Benefit Rider, and if specified as applicable on the Schedule of Benefits, the Certificate is amended as follows:

A. SECTION 3 – BENEFITS, A. Major Medical Benefits the following benefit is added:

[12.] Hearing Aids, not subject to Calendar Year Deductible [or Daily Deductible] or Copay, up to \$[1,400] per ear for each [three-year] period. The Hearing Aids must be dispensed by an individual properly licensed by the State of Arkansas.

B. SECTION 4 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE the following change is hereby made:

Item [#27] pertaining to routine hearing exams is amended by deleting the reference to “the purchase of hearing aids.”

C. SECTION 9 – DEFINITIONS the following definition is added:

Hearing Aid means an instrument or device, including repair and replacement parts, that:

- a) Is designed and offered for the purpose of aiding Covered Persons with or compensating for impaired hearing;
- b) Is worn in or on the body; and
- c) Is generally not useful to a person in the absence of a hearing impairment.

TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2009] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

SCHEDULE OF BENEFITS

[PLAN NAME]

Lifetime Maximum Benefit for all Covered Charges combined	\$[5,000,000]
[Lifetime Maximum Benefit for In-Network specified covered organ transplants in a Centers of Excellence]	\$[1,000,000]
Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants	\$[400,000]
Lifetime Maximum Benefit for Out-of-Network Specified Covered Organ Transplants	\$[200,000]
Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders Combined	\$[10,000]
Lifetime Maximum Benefit for Hospice Care	[6 months of Covered Charges]

MEDICAL DEDUCTIBLE[*], PER CALENDAR YEAR

	[When Dependents are not covered by the plan]	[When Dependents are covered by the plan*]
[Deductible:	\$[1,000, 1,700; 2,600; 3,500; 5,000, 10,000]	\$[2,500; 3,350; 5,150; 7,500; 10,000]

[Additional Deductibles:

Failure to Pre-Certify Inpatient Care	\$[500]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

Notwithstanding anything to the contrary found in the Certificate, additional Deductible for failure to pre certify do not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

[In-Network and Out-of-Network services accumulate in the aggregate to satisfy the Deductible amount for the Calendar Year.]

[*Primary Insured and covered Dependents share one common Deductible amount for the Calendar Year.

HSA Plan Deductibles and Out-of-Pocket Maximum will be adjusted annually based on changes mandated by the Federal Government.]

OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

[When Dependents are not covered by the plan]	[When Dependents are covered by the plan]
\$[2,500; 3,350; 5,000;7,500; 15,000]	\$[5,000; 6,150; 10,000;15,000]

[COPAYS

Physician office Visit or Free Standing Urgent Care Center Facility Visit at In-Network providers only.	\$[None, 20, 30]
Diagnostic x-ray, labs and tests at In-Network providers only (<i>applies for each provider</i>)	\$[None, 20, 30]]

COINSURANCE AND BENEFIT LIMITATIONS

All Benefit Limits are per Insured Person per Calendar Year.

	In-Network Benefit	Out-Of-Network Benefit
MEDICAL SERVICES AND SUPPLIES		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After Copay, then 100%] [100%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Outpatient Diagnostic Lab [not performed by LabOne]	[After Copay, then 100%] [100%, 70% after Deductible]	[70%, 80%, 90% after Deductible]
Outpatient Diagnostic X-ray and tests [not performed by LabOne]	[100%, 70% after Deductible]	[70%, 80%, 90% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[100%]
Physical, Speech, or Occupational Therapy	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Durable Medical Equipment	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Non-Surgical Back Treatment	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Outpatient Registered Nurse Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Home Health Care	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Hospice Care	[100%]	[100%]
Cytological & Mammography Screening Services	[100%]	[100%]
OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)		
Outpatient Hospital or Ambulatory Surgical Center Facility Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Surgery, Assistant Surgeon, and Anesthesiology Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]

FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)

Hospital Inpatient Facility Confinement	[100%, 70% after Deductible]	[70% , 50% after Deductible]
Skilled Nursing Facility Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Physician services, including consultations and diagnostic testing	[100%, 70% after Deductible]	[70%, 50% after Deductible]

EMERGENCY CARE

Emergency Room	[100%, 70% after Deductible]	[100%, 70% after Deductible]
Ambulance Services – Ground, Air, and Water	[100%, 70% after Deductible]	[100%, 70% after Deductible]

MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS

Mental and Nervous Inpatient Care	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Mental, Nervous and Chemical Dependency Outpatient Care	[50% after Deductible]	[50% after Deductible]

HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.		
Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]

BENEFIT LIMITS

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined, including organ transplants provided in a Centers of Excellence] \$[1,000,000]

Physical, Speech, or Occupational Therapy	[30 treatments per Calendar Year for any one type of therapy and up to 60 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$1,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60 visits per Calendar Year]
Hospice Care	[Limited to 6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$[2,400] per child
Skilled Nursing Facility Services	[Limited to \$100 daily and a maximum of 60 days per Calendar Year]
Mental and Nervous Inpatient Care	[A maximum 10 days per Calendar Year up to \$2,500 per Calendar Year]
Mental and Nervous Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Chemical Dependency Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
Oral Surgery	\$\$[5,000] per Calendar Year]

OPTIONAL BENEFITS

[Optional Wellness Benefit Rider [YES/NO]

[\$35 Copay, then 100% up to \$250, 350, 500]

[Optional 24-Hour Occupation Coverage Rider [YES/NO]

[Optional Prescription Medication Benefit Rider [YES/NO]

Prescription Medication Benefit

[OPTION 1	Bronze	Discount Drug Card
OPTION 2	Silver	Generic \$15 Copay, Brand Name discount only
OPTION 3	Gold	Generic \$15 Copay; Formulary Brand \$100 Copay; Non-formulary Brand \$150 Copay, Brand out-of-pocket Calendar Year maximum: \$3000 individual/\$5000 family
OPTION 4	Platinum 1	Generic \$20 Copay; Brand \$200 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 5	Platinum 2	Generic \$20 Copay; Brand \$100 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 6	Platinum 3	Generic \$20 Copay; Formulary Brand \$30 Copay or 20% coinsurance whichever is greater; Non-formulary Brand \$45 Copay or 50% coinsurance whichever is greater
OPTION 7	Rx HSA	Same as any other illness]

[*When three (3) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Primary Insured and covered Dependents share one common Deductible amount for the Calendar Year.]]

[Optional Dental Benefit Rider

[YES/NO]]

Plan 1

Plan 2

Lifetime Deductible

[\$25]

[\$25]

Calendar Year Deductible

[\$50 for Basic and Major, \$50 for Orthodontia (Maximum of three per family)]

[\$50 for Basic and Major (Maximum of three per family)]

Calendar Year Maximum

[\$1,500 for Preventive, Basic and Major \$1,000 for orthodontia]

[\$1,500 for Preventive, Basic and Major]

Lifetime Maximum

[\$1,000 for orthodontia]

[\$1,000 for orthodontia]

Waiting Periods

Preventive and Basic

[None]

Major and Orthodontic(if included)

[12 months]

Covered Procedures

Preventive Services (Type 1)

[Plan pays 100%]

[Plan pays 90%]

Basic Services(Type 2)

[Plan pays 80%]

[Plan pays 60%]

Major Service (Type 3) [Plan pays 50%] [Plan pays 50%]

Orthodontia (Type 4)
(for children under age 19) [Plan pays 50%] [No coverage]

[Optional Vision Benefit Rider] [YES/NO]

	In-Network Benefit	Out-Of-Network Benefit	Benefit Frequency
[Vision Exam	[\$10 or 20 copay]	[Up to \$35.00]	[12 Months]
Contact Lenses			[12 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	[Up to \$100.00]	
Disposable	[\$115.00 Allowance + 100% of the balance over \$115.00]	[Up to \$100.00]	
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to \$200.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12 Months]
Glasses Lenses			[12 Months]
Single vision	[\$25.00 copay]	[Up to \$25.00]	
Bifocal	[\$25.00 copay]	[Up to \$40.00]	
Trifocal	[\$25.00 copay]	[Up to \$55.00]	
Lenticular	[\$25.00 copay]	[Up to \$55.00]	
In-Network Lens Options (Additional Copays)	[\$45.00]	[N/A]	
Basic Progressives*	[\$35.00]	[N/A]	
Basic Polycarbonate	[\$12.00]	[N/A]	
Ultra violet	[\$45.00]	[N/A]	
Basic Anti-Reflective	[\$12.00]	[N/A]	
Tint (Solid & Gradient)	[\$15.00]	[N/A]	
Basic Scratch-Resistance	[20% discount]	[N/A]	
Other Add-Ons & Service			

[*add-on to bifocal]

[Optional Life and Accidental Death and Dismemberment Benefit Rider] [YES/NO]

Life Insurance Amount	[\$10,000-\$100,000]
Accidental Death and Dismemberment Insurance	[The Principal Sum is equal to one times the Life Insurance Amount]

[Optional Dependent Life Insurance]

Spouse Life Insurance Amount	[\$2,000]
Children	
Age 14 days, but less than 6 months	[\$ 100]
age 6 months, but less than 19 years	[\$1,000]
age 19 years, but less than 25 years (if a student attending school on a full-time basis)]	[\$1,000]

[Optional Supplemental Accident Coverage]

[YES/NO]
[100% up to a \$500 or \$1,000 or \$1,500 or \$2,000 maximum benefit then copay, Deductible and coinsurance]

[Optional Weekly Disability Benefit]

[YES/NO]
[Up to a maximum benefit of \$[100][200][300][500] per week]]

[Benefits begin:
Day 1 due to an accident
Day 8 due to a sickness
Up to 26 weeks per disability.]

[Optional Pregnancy Benefit]

[YES/NO]

[Optional for groups of 5-14(fewer where mandated), mandatory for 15+]

[In-Network
Subject to Deductibles and coinsurance

Out-of-Network
Subject to Deductibles and Coinsurance]

In-Vitro Fertilization lifetime maximum benefit - \$[15,000]

SCHEDULE OF BENEFITS
[PLAN NAME]

Lifetime Maximum Benefit for all Covered Charges combined	\$[5,000,000]
[Lifetime Maximum Benefit for In-Network specified covered organ transplants in a Centers of Excellence]	\$[1,000,000]
Lifetime Maximum Benefit for In-Network specified covered organ transplants	\$[400,000]
Lifetime Maximum Benefit for Out-of-Network specified covered organ transplants	\$[200,000]
Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders combined	\$[10,000]
Lifetime Maximum Benefit for Hospice Care	[6 months of Covered Charges]

MEDICAL DEDUCTIBLE, PER CALENDAR YEAR

	[IN NETWORK]	[OUT-OF-NETWORK]
[Deductible:	\$[500; 750; 1,000; 1,500; 2,000; 5,000]	\$[1,000; 1,500; 2,000; 3,000; 4,000; 10,000]

[The In-Network and Out-of-Network Deductibles are accumulated separately. However, when the Out-of-Network Deductible is met for the Calendar Year, the In-Network Deductible will be deemed satisfied for the remainder of that Calendar Year.]

[Deductible Maximum: When three (3) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.]
 [Employee and Dependents share one common Deductible amount for the Calendar Year.]

[Additional Deductibles:

Failure to Pre-Certify Inpatient Care	\$[500]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

[Notwithstanding anything to the contrary found in the Certificate, the additional Deductible for failure to pre certify does not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

In-Network	Out-of-Network
\$[1,000][1,500][2,000][3,000][4,500]	\$[2,000][3,000][4,000][6,000][7,500]

OR

[OUT-OF-POCKET MAXIMUM AMOUNT PER CALENDAR YEAR FOR EACH INSURED PERSON]

	[In Network]	[Out-Of-Network]
[Medical Services & Supplies]	\$[2,000]	\$[5,000]
[Inpatient Facility Confinement & Surgical Services]	\$[4,000]	\$[10,000]

[The In-Network and Out-of-Network Calendar Year Out-of-Pocket Maximums are accumulated separately, except when the Out-of-Network Calendar Year Out-of-Pocket Maximum is satisfied, the In-Network Out-of-Pocket Maximum will be deemed satisfied for the remainder of that Calendar Year. The following Covered Charges do not accumulate toward the Maximum Out-of-Pocket Amount Per Calendar Year: (1) Expenses incurred for the Outpatient treatment of Mental, Nervous or Chemical Dependency Disorders; (2) Pre-Certification Deductibles; (3) Copays; (4) Any Deductible amounts.]

[Maximum Out-of-Pocket Amount per Calendar Year per insured family: Once any two (2) Insured Persons in an Insured family (an Employee and his or her Insured Dependents) have satisfied their individual Maximum Out-of-Pocket Amounts per Calendar Year, all other Insured Persons in the insured family will be deemed to have satisfied this requirement for the remainder of the Calendar Year]

[COPAYS

Physician office visit charge for examination and evaluation at In-Network providers only.		\$[None, 20, 25, 30, 50]
Emergency Room Copay <i>(waived if the Insured Person is admitted or the visit is determined to be Medically Necessary Emergency Care)</i>		[\$100]
Emergency Ambulance Services – Ground, Air, and Water		[\$100]]
	[In-Network	Out-of-Network]
[Inpatient Facility Confinement]	[\$250]	[\$500]
[Outpatient Surgery]	[\$250]	[\$500]

COINSURANCE AND BENEFIT LIMITATIONS

All Benefit Limits are per Insured Person per Calendar Year.

	In-Network Benefit	Out-Of-Network Benefit
MEDICAL SERVICES AND SUPPLIES		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After Copay, then 100% after] [90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Outpatient Diagnostic Lab, X-ray and tests [not performed by LabOne]	[90%, 80%, 70% after Deductible]	[70%, 80%, 90% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[100%]
Physical, Speech, or Occupational Therapy	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Durable Medical Equipment	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Non-Surgical Back Treatment	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]

Outpatient Registered Nurse Services	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Home Health Care	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Hospice Care	[100%]	[100%]
Cytological & Mammography Screening Services	[100%]	[100%]

OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)

Outpatient Hospital or Ambulatory Surgical Center Facility Services	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Surgery, Assistant Surgery, and Anesthesiology Services	[After Copay then] [90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]

FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)

Inpatient Facility Confinement	[After Copay then] [90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Skilled Nursing Facility Services	[After Copay then] [90%, 80%, 70% after Deductible]	[After Copay then] [70%, 60%, 50% after Deductible]
Physician services, including consultations and diagnostic testing	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]

EMERGENCY CARE

Emergency Room	[After Copay, then 90%, 80%, 70% after Deductible]	[After Copay, then 90%, 80%, 70% after Deductible]
Ambulance Services – Ground, Air, and Water	[After Copay, then 90%, 80%, 70% after Deductible]	[After Copay, then 90%, 80%, 70% after Deductible]

MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS

Mental and Nervous Inpatient Care	[90%, 80%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Mental, Nervous and Chemical Dependency Outpatient Care	[50% after Deductible]	[50% after Deductible]

HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-Private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced Private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.		
Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]

BENEFIT LIMITS

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined, including organ transplants covered in a Centers of Excellence] \$[1,000,000]

Physical, Speech, or Occupational Therapy	[30 treatments per Calendar Year for any one type of therapy and up to 60 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$1,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60 visits per Calendar Year]
Hospice Care	[Limited to 6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$[2,400] per child
Skilled Nursing Facility Services	[Limited to \$100 daily and a maximum of 60 days per Calendar Year]
Mental and Nervous Inpatient Care	[A maximum 10 days per Calendar Year up to \$2,500 per Calendar Year]
Mental and Nervous Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Chemical Dependency Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
Oral Surgery	[\$[1,000]][3,000]][5,000] per Calendar Year]

OPTIONAL BENEFITS

- [Optional Wellness Benefit Rider** [YES/NO]
[\$35 Copay, then 100% up to \$250, 350, 500]
- [Optional 24-Hour Occupation Coverage Rider** [YES/NO]
- [Optional Prescription Medication Benefit Rider** [YES/NO]

Prescription Medication Benefit

OPTION 1	Bronze	Discount Drug Card
OPTION 2	Silver	Generic \$15 Copay, Brand Name discount only
OPTION 3	Gold	Generic \$15 Copay; Formulary Brand \$100 Copay; Non-formulary Brand \$150 Copay, Brand out-of-pocket Calendar Year maximum: \$3000 individual/\$5000 family
OPTION 4	Platinum 1	Generic \$20 Copay; Brand \$200 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 5	Platinum 2	Generic \$20 Copay; Brand \$100 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 6	Platinum 3	Generic \$20 Copay; Formulary Brand \$30 Copay or 20% coinsurance whichever is greater; Non-formulary Brand \$45 Copay or 50% coinsurance whichever is greater

[*When three (3) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Employee and Dependents share one common Deductible amount for the Calendar Year.]

[Optional Dental Benefit Rider	[YES/NO]	
	Plan 1	Plan 2
Lifetime Deductible	[\$25]	[\$25]
Calendar Year Deductible	[\$50 for Basic and Major, \$50 for Orthodontia (Maximum of three per family)]	[\$50 for Basic and Major (Maximum of three per family)]
Calendar Year Maximum	[\$1,500 for Preventive, Basic and Major, \$1,000 for orthodontia]	[\$1,500 for Preventive, Basic and Major]

Lifetime Maximum	[\$1,000 for orthodontia]		
Waiting Periods Preventive and Basic Major and Orthodontic(if included)	[None] [12 months]		[None] [12 months]
Covered Procedures Preventive Services (Type 1)	[Plan pays 100%]		[Plan pays 90%]
Basic Services(Type 2)	[Plan pays 80%]		[Plan pays 60%]
Major Service (Type 3)	[Plan pays 50%]		[Plan pays 50%]
Orthodontia (Type 4) (for children under age 19)	[Plan pays 50%]		[Not Covered]
[Optional Vision Benefit Rider	[YES/NO]		
	In-Network Benefit	Out-Of- Network Benefit	Benefit Frequency
[Vision Exam	[\$10.00 copay]	[Up to \$35.00]	[12 Months]
Contact Lenses			[12 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	[Up to \$100.00]	
Disposable	[\$115.00 Allowance + 100% of the balance over \$115.00]	[Up to \$100.00]	
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to \$200.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12 Months]
Glasses Lenses			[12 Months]
Single vision	[\$25.00 copay]	[Up to \$25.00]	
Bifocal	[\$25.00 copay]	[Up to \$40.00]	
Trifocal	[\$25.00 copay]	[Up to \$55.00]	
Lenticular	[\$25.00 copay]	[Up to \$55.00]	
In-Network Lens Options – Additional Copays	[\$45.00]	[N/A]	
Basic Progressives*	[\$35.00]	[N/A]	

Basic Polycarbonate	[\$12.00]	[N/A]
Ultra violet	[\$45.00]	[N/A]
Basic Anti-Reflective	[\$12.00]	[N//A]
Tint (Solid & Gradient)	[\$15.00]	[N/A]
Basic Scratch-Resistance	[20% discount[[N/A]]
Other Add-Ons & Service		

*add-on to bifocal]

[Optional Life and Accidental Death and Dismemberment Benefit Rider [YES/NO]]

Life Insurance Amount \$[10,000-100,000]
 Accidental Death and Dismemberment Insurance The Principal Sum is equal to one times the Life Insurance Amount]

[Optional Dependent Life Insurance]

Spouse Life Insurance Amount [\$2,000]
 Children
 Age 14 days, but less than 6 months [\$ 100]
 age 6 months, but less than 19 years [\$1,000]
 age 19 years, but less than 25 years
 (if a student attending school on a full-time basis) [\$1,000]

[Optional Supplemental Accident Coverage] [YES/NO]]

[100% up to a \$500 or \$1,000 or \$1,500 or \$2,000 maximum benefit amount as specified on your Validation of Coverage Face Page]

[Optional Weekly Disability Benefit] [YES/NO]]

[Benefits begin:
 Day 1 due to an accident [Up to a maximum benefit of \$[100][200][300][500] per week]
 Day 8 due to a sickness
 Up to 26 weeks per disability.]

[Optional Pregnancy Benefit] [YES/NO]

[Optional for groups of 5-14(fewer where mandated), mandatory for 15+]	In-Network Subject to Deductibles and coinsurance	Out-of-Network Subject to Deductibles and Coinsurance]
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In-Vitro Fertilization lifetime maximum benefit - \$[15,000]

SCHEDULE OF BENEFITS

[PLAN NAME]

Lifetime Maximum Benefit for all Covered Charges combined	\$[5,000,000]
[Lifetime Maximum Benefit for In-Network specified covered organ transplants in a Centers of Excellence]	\$[1,000,000]
Lifetime Maximum Benefit for In-Network specified covered organ transplants	\$[400,000]
Lifetime Maximum Benefit for Out-of-Network specified covered organ transplants	\$[200,000]
Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders combined	\$[10,000]
Lifetime Maximum Benefit for Hospice Care	[6 months of Covered Charges]

MEDICAL DEDUCTIBLE, PER CALENDAR YEAR

\$[500; 750; 1,000; 1,500; 2,500; 5,000; 5,000; 7,500; 10,000]

[Deductible:

[Deductible Maximum: When three (3) individual Insured Persons in a family satisfy their Calendar Year Deductibles, the Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Employee and covered Dependents share one common deductible amount for the Calendar Year.]

[Additional Deductibles:

Failure to Pre-certify Inpatient Care	\$[500]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

Notwithstanding anything to the contrary found in the Certificate, the additional Deductible for failure to pre certify does not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

\$[1,000][2,000][3,000][4,000][5,000][10,000]

[Maximum Out-of-Pocket Amount per Calendar Year per insured family: Once any two (2) Insured Persons in an insured family (an Employee and his or her Dependents) have satisfied their individual Maximum Out-of-Pocket Amounts per Calendar Year, all other Insured Persons in the insured family will be deemed to have satisfied this requirement for the remainder of the Calendar Year]

[COPAYS

Physician office visit charge for examination and evaluation by In-Network providers only.	\$[None, 20, 25, 30, 50]
Emergency Room Copay <i>(waived if the Insured Person is admitted or the visit is determined to be Medically Necessary Emergency Care)</i>	\$[100]
Emergency Ambulance Services – Ground, Air, and Water	\$[100]

[Inpatient Facility Confinement]	\$[250]
[Outpatient Surgery]	\$[500]

COINSURANCE AND BENEFIT LIMITATIONS

All Benefit Limits are per Insured Person per Calendar Year.

MEDICAL SERVICES AND SUPPLIES

Physician Office Visit or Free Standing Urgent Care Center Visit	[After Copay, then 100% after] [80%, 70%, 50% after Deductible]
Outpatient Diagnostic Lab, X-ray and tests [not performed by LabOne]	[80%, 70%, 50% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]
Physical, Speech, or Occupational Therapy	[80%, 70%, 50% after deductible]
Durable Medical Equipment	[80%, 70%, 50% after deductible]
Non-Surgical Back Treatment	[80%, 70%, 50% after deductible]
Outpatient Registered Nurse Services	[80%, 70%, 50% after deductible]
Home Health Care	[80%, 70%, 50% after deductible]
Hospice Care	[100%]
Cytological & Mammography Screening Services	[100%]

OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)

Outpatient Hospital or Ambulatory Surgical Center Facility Services	[80%, 70%, 50% after deductible]
Surgery, Assistant Surgery, and Anesthesiology Services	[After Copay then] [80%, 70%, 50% after deductible]

FACILITY CHARGES (Inpatient surgical or other services when rendered at a Inpatient Facility)

Inpatient Facility Confinement	[After Copay then][80%, 70%, 50% after deductible]
Skilled Nursing Facility Services	[After Copay then][80%, 70%, 50% after deductible]
Physician services, including consultations and diagnostic testing	[80%, 70%, 50% after deductible]

EMERGENCY CARE

Emergency Room	[After Copay, then 80%, 70%, 50% after deductible]
Ambulance Services – Ground, Air, and Water	[After Copay, then 80%, 70%, 50% after deductible]

MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS

Mental and Nervous Inpatient Care	[80%, 70%, 50% after deductible]
Mental, Nervous and Chemical Dependency Outpatient Care	[50% after deductible]

HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable deductibles and coinsurance will apply)

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced private room rate. In the event a private room is medically necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.	
Intensive Care Unit	[Up to the Most Common ICU Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]

BENEFIT LIMITS

All Benefit Limits are per Insured Person per Calendar Year

Calendar Year Maximum Benefit for all Covered Charges combined, including organ transplants provided in a Centers of Excellence	\$[1,000,000]
Physical, Speech, or Occupational Therapy	[30 treatments per Calendar Year for any one type of therapy and up to 60 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$1,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60 visits per Calendar Year]
Hospice Care	[Limited to 6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$[2,400] per child
Skilled Nursing Facility Services	[Limited to \$100 daily and a maximum of 60 days per Calendar Year]
Mental and Nervous Inpatient Care	[A maximum 10 days per Calendar Year up to \$2,500 per Calendar Year]
Mental and Nervous Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Chemical Dependency Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
Oral Surgery	\$ [5,000] per Calendar Year]

OPTIONAL BENEFITS

[Optional Wellness Benefit Rider	[YES/NO]
	[\$35 Copay, then 100% up to \$250, 350, 500]
[Optional 24-Hour Occupation	[YES/NO]

Coverage Rider

[Optional Prescription Medication [YES/NO]

Benefit Rider

Prescription Medication Benefit

OPTION 1	Bronze	Discount Drug Card
OPTION 2	Silver	Generic \$15 Copay, Brand Name discount only
OPTION 3	Gold	Generic \$15 Copay; Formulary Brand \$100 Copay; Non-formulary Brand \$150 Copay, Brand out-of-pocket Calendar Year maximum: \$3000 individual/\$5000 family
OPTION 4	Platinum 1	Generic \$20 Copay; Brand \$200 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 5	Platinum 2	Generic \$20 Copay; Brand \$100 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 6	Platinum 3	Generic \$20 Copay; Formulary Brand \$30 Copay or 20% coinsurance whichever is greater; Non-formulary Brand \$45 Copay or 50% coinsurance whichever is greater]

[*When three (3) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Primary Insured and covered Dependents share one common deductible amount for the Calendar Year.]

[Optional Dental Benefit Rider

[YES/NO]]

	Plan 1	Plan 2
Lifetime Deductible	[\$25]	[\$25]
Calendar Year Deductible	[\$50 for Basic and Major, \$50 for Orthodontia (Maximum of three per family)]	[\$50 for Basic and Major (Maximum of three per family)]
Calendar Year Maximum	[\$1,500 for Preventive, Basic and Major \$1,000 for orthodontia]	[\$1,500 for Preventive, Basic and Major]
Lifetime Maximum	[\$1,000 for orthodontia]	
Waiting Periods		
Preventive and Basic	[None]	[None]
Major and Orthodontic(if included)	[12 months]	[12 months]
Covered Procedures		

Preventive Services (Type 1)	[Plan pays 100%]	[Plan pays 90%]
Basic Services(Type 2)	[Plan pays 80%]	[Plan pays 60%]
Major Service (Type 3)	[Plan pays 50%]	[Plan pays 50%]
Orthodontia (Type 4) (for children under age 19)	[Plan pays 50%]	[Not Covered]

[Optional Vision Benefit Rider

[YES/NO]

	Benefit	Benefit Frequency
[Vision Exam	[\$10.00 copay]	[12 Months]
Contact Lenses		[12 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	
Disposable	[\$115.00 Allowance + 100% of the balance over \$115.00]	
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[12 Months]
Glasses Lenses		
Single vision	[\$25.00 copay]	[12 Months]
Bifocal	[\$25.00 copay]	
Trifocal	[\$25.00 copay]	
Lenticular	[\$25.00 copay]	
In-Network Lens Options (Additional Copays)	[\$45.00]	
Basic Progressives*	[\$35.00]	
Basic Polycarbonate	[\$12.00]	
Ultra violet	[\$45.00]	
Basic Anti-Reflective	[\$12.00]	
Tint (Solid & Gradient)	[\$15.00]	
Basic Scratch-Resistance	[20% discount]	
Other Add-Ons & Service		

*add-on to bifocal]

[Optional Life and Accidental Death and

Dismemberment Benefit Rider [YES/NO]
 Life Insurance Amount
 Accidental Death and Dismemberment Insurance \$[10,000-100,000]
 The Principal Sum is equal to one times the Life Insurance Amount

[Optional Dependent Life Insurance]

Spouse Life Insurance Amount [\$2,000]
 Children
 Age 14 days, but less than 6 months [\$ 100]
 age 6 months, but less than 19 years [\$1,000]
 age 19 years, but less than 25 years
 (if a student attending school on a full-time basis) [\$1,000]

[Optional Supplemental Accident Coverage] [YES/NO]
 [100% up to a \$500 or \$1,000 or \$1,500 or \$2,000 maximum benefit amount as specified on your Validation of Coverage Face Page]

[Optional Weekly Disability Benefit] [YES/NO]
 [Benefits begin: [Up to a maximum benefit of \$[100][200][300][500] per week]
 Day 1 due to an accident
 Day 8 due to a sickness
 Up to 26 weeks per disability.]

[Optional Pregnancy Benefit] [YES/NO]
 [Optional for groups of 5-14(fewer where mandated), mandatory for 15+] [Subject to deductibles and coinsurance]

In-Vitro Fertilization lifetime maximum benefit - \$[15,000]

SCHEDULE OF BENEFITS

[PLAN NAME]

Lifetime Maximum Benefit for all Covered Charges combined	\$[5,000,000]
[Lifetime Maximum Benefit for In-Network specified covered organ transplants in a Centers of Excellence]	\$[1,000,000]
Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants	\$[400,000]
Lifetime Maximum Benefit for Out-of-Network Specified Covered Organ Transplants	\$[200,000]
Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders Combined	\$[10,000]
Lifetime Maximum Benefit for Hospice Care	[6 months of Covered Charges]

MEDICAL DEDUCTIBLE[*], PER CALENDAR YEAR

[Deductible amount per person per calendar day

For each calendar day in which You incur Covered Charges, You are responsible for an amount up to Your Daily Deductible Selection. The Daily Deductible amount applies per calendar day, regardless of the number of providers rendering services in that calendar day. Once your Daily Deductible amount has been satisfied for the calendar day, any remaining balance is paid by the Plan at 100%.

	[When Dependents are not covered by the plan] [In-Network/Out-of-Network]	[When Dependents are covered by the plan*] [In-Network/Out-of-Network]
	\$[250/500 Or 500/1000]	\$[500/1000 Or 1000/2000]

[The In-Network and Out-of-Network Daily Deductibles accumulate separately and distinctly.]

[Additional Deductibles:

Failure to Pre-Certify Inpatient Care	\$[500]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

[Notwithstanding anything to the contrary found in the Certificate, the additional Deductible for failure to pre certify do not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

[*Primary Insured and covered Dependents share one common Deductible amount for the Calendar Year.]

OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

[When Dependents are not covered by the plan] [In-Network/Out-of-Network]	[When Dependents are covered by the plan] [In-Network/Out-of-Network]
\$[4,000/8,000]	\$[4,000/8,000]

[COPAYS

Physician office Visit or Free Standing Urgent Care Center Facility Visit at In-Network providers only.	\$[None, 20, 30]
Diagnostic x-ray, labs and tests at In-Network providers only (<i>applies for each provider</i>)	\$[None, 20, 30]

COINSURANCE AND BENEFIT LIMITATIONS

All Benefit Limits are per Insured Person per Calendar Year.

	In-Network Benefit	Out-Of-Network Benefit
MEDICAL SERVICES AND SUPPLIES		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After Copay, then 100%] [100%, 70% after Deductible]	[70%, 60%, 50% after Deductible]
Outpatient Diagnostic Lab [not performed by LabOne]	[After Copay, then 100%] [100%, 70% after Deductible]	[70%, 80%, 90% after Deductible]
Outpatient Diagnostic X-ray and tests [not performed by LabOne]	[100%, 70% after Deductible]	[70%, 80%, 90% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[100%]
Physical, Speech, or Occupational Therapy	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Durable Medical Equipment	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Non-Surgical Back Treatment	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Outpatient Registered Nurse Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Home Health Care	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Hospice Care	[100%]	[100%]
Cytological & Mammography Screening Services	[100%]	[100%]

OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)

Outpatient Hospital or Ambulatory Surgical Center Facility Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Surgery, Assistant Surgeon, and Anesthesiology Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]

FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)

Hospital Inpatient Facility Confinement	[100%, 70% after Deductible]	[70% , 50% after Deductible]
Skilled Nursing Facility Services	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Physician services, including consultations and diagnostic testing	[100%, 70% after Deductible]	[70%, 50% after Deductible]

EMERGENCY CARE

Emergency Room	[100%, 70% after Deductible]	[100%, 70% after Deductible]
Ambulance Services – Ground, Air, and Water	[100%, 70% after Deductible]	[100%, 70% after Deductible]

MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS

Mental and Nervous Inpatient Care	[100%, 70% after Deductible]	[70%, 50% after Deductible]
Mental, Nervous and Chemical Dependency Outpatient Care	[50% after Deductible]	[50% after Deductible]

HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.		
Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]

BENEFIT LIMITS

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined, including organ transplants provided in a Centers of Excellence]	\$[1,000,000]
Physical, Speech, or Occupational Therapy	[30 treatments per Calendar Year for any one type of therapy and up to 60 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$1,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60 visits per Calendar Year]
Hospice Care	[Limited to 6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$[2,400] per child
Skilled Nursing Facility Services	[Limited to \$100 daily and a maximum of 60 days per Calendar Year]
Mental and Nervous Inpatient Care	[A maximum 10 days per Calendar Year up to \$2,500 per Calendar Year]
Mental and Nervous Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Chemical Dependency Outpatient Care	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
Oral Surgery	\$ [5,000] per Calendar Year]

OPTIONAL BENEFITS

- [Optional Wellness Benefit Rider** [YES/NO]
[\$35 Copay, then 100% up to \$250, 350, 500]
- [Optional 24-Hour Occupation Coverage Rider** [YES/NO]
- [Optional Prescription Medication Benefit Rider** [YES/NO]
Prescription Medication Benefit

OPTION 1	Bronze	Discount Drug Card
OPTION 2	Silver	Generic \$15 Copay, Brand Name discount only
OPTION 3	Gold	Generic \$15 Copay; Formulary Brand \$100 Copay; Non-formulary Brand \$150 Copay, Brand out-of-pocket Calendar Year maximum: \$3000 individual/\$5000 family
OPTION 4	Platinum 1	Generic \$20 Copay; Brand \$200 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 5	Platinum 2	Generic \$20 Copay; Brand \$100 Deductible; Formulary \$30 Copay or 20% coinsurance whichever is greater; Non-formulary \$45 Copay or 50% coinsurance whichever is greater
OPTION 6	Platinum 3	Generic \$20 Copay; Formulary Brand \$30 Copay or 20% coinsurance whichever is greater; Non-formulary Brand \$45 Copay or 50% coinsurance whichever is greater
OPTION 7	Rx HSA	Same as any other illness]

[*When three (3) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Primary Insured and covered Dependents share one common Deductible amount for the Calendar Year.]]

[Optional Dental Benefit Rider	[YES/NO]]	
	Plan 1	Plan 2
Lifetime Deductible	[None]	[None]
Calendar Year Deductible	[\$25]	[\$25]
Calendar Year Maximum	[\$50 for Basic and Major, \$50 for Orthodontia (Maximum of three per family)]	[\$50 for Basic and Major (Maximum of three per family)]
Lifetime Maximum	[\$1,500 for Preventive, Basic and Major \$1,000 for orthodontia]	[\$1,500 for Preventive, Basic and Major]
Waiting Periods Preventive and Basic	[None]	[None]
Major and Orthodontic(if included)	[12 months]	[12 months]
Covered Procedures		
Preventive Services (Type 1)	[Plan pays 100%]	[Plan pays 90%]
Basic Services(Type 2)	[Plan pays 80%]	[Plan pays 60%]
Major Service (Type 3)	[Plan pays 50%]	[Plan pays 50%]

Orthodontia (Type 4)
(for children under age 19)

[Plan pays 50%]

[No coverage]

[Optional Vision Benefit Rider

[YES/NO]]

	[In-Network Benefit]	[Out-Of- Network Benefit]	[Benefit Frequency]
[Vision Exam	[\$10 or 20 copay]	[Up to \$35.00]	[12 Months]
Contact Lenses			[12 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	[Up to \$100.00]	
Disposable	[\$115.00 Allowance + 100% of the balance over \$115.00]	[Up to \$100.00]	
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to \$200.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12 Months]
Glasses Lenses			[12 Months]
Single vision	[\$25.00 copay]	[Up to \$25.00]	
Bifocal	[\$25.00 copay]	[Up to \$40.00]	
Trifocal	[\$25.00 copay]	[Up to \$55.00]	
Lenticular	[\$25.00 copay]	[Up to \$55.00]	
In-Network Lens Options (Additional Copays)			
Basic Progressives*	[\$45.00]	[N/A]	
Basic Polycarbonate	[\$35.00]	[N/A]	
Ultra violet	[\$12.00]	[N/A]	
Basic Anti-Reflective	[\$45.00]	[N/A]	
Tint (Solid & Gradient)	[\$12.00]	[N//A]	
Basic Scratch-Resistance	[\$15.00]	[N/A]	
Other Add-Ons & Service	[20% discount]	[N/A]	

[*add-on to bifocal]]

[Optional Life and Accidental Death and Dismemberment Benefit Rider

[YES/NO]]

Life Insurance Amount [\$10,000-\$100,000]
 Accidental Death and Dismemberment Insurance [The Principal Sum is equal to one times the Life Insurance Amount]

[Optional Dependent Life Insurance]

Spouse Life Insurance Amount [\$2,000]

Children

Age 14 days, but less than 6 months [\$ 100]
 age 6 months, but less than 19 years [\$1,000]
 age 19 years, but less than 25 years
 (if a student attending school on a full-time basis) [\$1,000]

[Optional Supplemental Accident Coverage]

[YES/NO]
 [100% up to a \$500 or \$1,000 or \$1,500 or \$2,000 maximum benefit then copay, Deductible and coinsurance]

[Optional Weekly Disability Benefit]

[YES/NO]

[Benefits begin:
 Day 1 due to an accident [Up to a maximum benefit of \$[100][200][300][500] per
 Day 8 due to a sickness week]
 Up to 26 weeks per disability.]

[Optional Pregnancy Benefit]

[YES/NO]

[Optional for groups of 5-14(fewer where mandated), mandatory for 15+]

[In-Network
 Subject to Deductibles and coinsurance

Out-of-Network
 Subject to Deductibles and Coinsurance]

In-Vitro Fertilization lifetime maximum benefit - \$[15,000]

Madison National Life Insurance Company, Inc.
[1241 John Q Hammons Drive Madison, WI 53717]

POLICYHOLDER ELECTION FORM
ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, and in consideration of any applicable additional premium for each Arkansas resident Certificate holder for each benefit option selected, Covered Charges will include all or any of the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

[1.] Accept _____ Reject _____ Hearing Aids (Act 1179 of 2009/Bulletin 7A-2009)

As the Policyholder, we request that you indicate above whether you accept or reject this optional benefit:

Policyholder Name: _____

Signed for the Policyholder _____

Name _____ Title _____ Date _____

SERFF Tracking Number: IADC-126566448 State: Arkansas
 Filing Company: Madison National Life Insurance Company Inc State Tracking Number: 45348
 Company Tracking Number: MNL SMGRP HEARING AID RIDER
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
 Product Name: Act 1179 Compliance - Hearing Aids
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/19/2010
Comments:		
Attachment: ARCertificate of ComplianceMNL033010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	05/19/2010
Comments: Application forms approved under SERFF Tracking #ICCI-126586569 approved May 12, 2010.		

	Item Status:	Status Date:
Satisfied - Item: 3rd Party Authorization	Approved-Closed	05/19/2010
Comments:		
Attachment: MNL Authorization Letter 2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	05/19/2010
Comments:		
Attachment: MNL(AR)filing letter 033010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certificate of Compliance	Approved-Closed	05/19/2010
Comments:		
Attachment:		

SERFF Tracking Number: IADC-126566448 State: Arkansas
Filing Company: Madison National Life Insurance Company Inc State Tracking Number: 45348
Company Tracking Number: MNL SMGRP HEARING AID RIDER
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
Product Name: Act 1179 Compliance - Hearing Aids
Project Name/Number: /
ARCertificate of ComplianceMNL051710.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s):

MNLMMC HEARDAE AR 0310

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

Signature of Company Officer:



Adam Vandervoort
Name

Secretary
Title

03/30/10
Date

January 29, 2010

RE: Madison National Life Insurance Company, Inc.

NAIC Company Number: 65781
NAIC Group Number: 0450
FEIN Number: 39-0990296

AUTHORIZATION STATEMENT

Madison National Life Insurance Company, Inc. ("MNL") hereby authorizes IHC Health Solutions (Member of the IHC Group) to represent us in the submission of accident and health insurance forms and rates and to negotiate with the Department for their approval.

Sincerely,



Adam C. Vandervoort
Secretary



2101 W Peoria Avenue #100
Phoenix, AZ 85029

March 31, 2010

Honorable Jay Bradford
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 Company Number: 65781
NAIC Group Number: 0450
FEIN Number: 39-0990296
Group Major Medical Expense Policy form MNL MMC 0205 and Related Forms

New Form:
MNL MMC HEARDAE AR 0310 [Optional] Hearing Aid Benefit Rider

Dear Commissioner Bradford:

We are submitting for your review and approval, the above referenced out-of-state Group Policy forms on behalf of Madison National Life Insurance Company, Inc.{MNL}. This filing is being made in order to comply with Bulletin 7A-2009 & Act 1179 of 2009 regarding the mandatory offering of hearing aids. The Hearing Aid Benefit Rider is a new form and will not replace any approved forms currently on file with the Department. The original policy form approval date is June 30, 2005. We will list this rider on the Schedule of Benefits as applicable or not applicable, depending on the applicant's selection.

IHC has received authorization to file life, accident, and health forms on MNL's behalf. For your reference, we have enclosed the filing letter of authorization from MNL. Additionally, we have also included a Certification signed by an officer of MNL, in accordance with Rule and Regulation 19.

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. We confirm that the forms meet the minimum required readability standards.

For any questions or if any additional information is needed, please contact me at (602)-861-6070, or by email: howards@iacusa.com. Thank you for your prompt consideration of this filing.

Sincerely,

Shellie Howard

Shellie Howard
Form Development & Compliance Specialist
PH: 602-861-6070

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s):

MNLMMC HEARDAE AR 0310
MNL MMC SD SB 0510 AR
MNL MMC PPO SB 0510 AR
MNL IND SB 0510 AR
MNL MMC DD SB 0510 AR
MNL AEAR OPT ELC AR 0510

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

Signature of Company Officer:



Adam Vandervoort
Name

Secretary
Title

05/17/10
Date

SERFF Tracking Number: IADC-126566448 State: Arkansas
 Filing Company: Madison National Life Insurance Company Inc State Tracking Number: 45348
 Company Tracking Number: MNL SMGRP HEARING AID RIDER
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
 Product Name: Act 1179 Compliance - Hearing Aids
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/31/2010		Supporting Application Document	05/17/2010	