MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • Phone: 1-800-356-9601
Administered By: North American Benefits Company (NABCO) 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF INSURANCE

PLEASE READ THIS CERTIFICATE CAREFULLY.

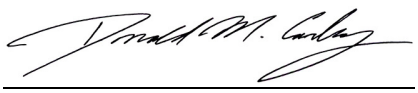
A PRE-EXISTING CONDITION EXCLUSION MAY APPLY

This Certificate of Insurance (hereafter referred to as "Certificate") is evidence of insurance provided under the Group Policy issued to, and held by, the Group Policyholder (as shown in the "Schedule Page"). If You have a Critical Illness while insured under this Certificate, We will pay Benefits according to the terms of this Certificate. This Certificate describes the essential features of the insurance.

The Group Policy is the agreement between the Group Policyholder and Us. The Group Policy may be amended at any time without notice to You. Any amendment will not affect a claim occurring before the amendment takes effect. You may inspect the Group Policy at any time during business hours at the office of the Group Policyholder.

Executed by Madison National Life Insurance Company, Inc.

Marita Zuraitis
President



Donald M. Carley
Corporate Secretary

SPECIFIED DISEASE INSURANCE

GUARANTEED ISSUE

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which You can get from Us.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE OR MEDICAL OR DISABILITY INSURANCE. RECEIPT OF BENEFITS UNDER THIS CERTIFICATE MAY AFFECT ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS AND/OR ENTITLEMENTS.

NON-PARTICIPATING

Table of Contents

Schedule of Benefits
("Schedule Page")

Administrative
Group Policyholder: County of Flathead School District #5

Group number: WS00103

Group Effective Date: July 1, 2022

Eligible Class(es): Class 1- All Eligible Persons

Minimum Hourly Work Requirement: 25 hours per week

Waiting Period for insurance: Not Applicable

Annual enrollment period: Limited to one annual enrollment in a 12-month period.
Special enrollment period: Included

Insured: Insurance to age 80
Dependent: Spouse insurance to age 80 and Child insurance to age 26

Premium Contribution
Insured: Applicable
Dependents: Applicable
Group Policyholder: Not Applicable

Critical Illness Benefit Amount
Insured: $10,000
Spouse: $ 5,000
Child: $ 5,000

Critical Illness Benefit Amount Multiplier 2x

Only the following Covered Conditions are subject to multiple Benefit payments:
- Cancer
- Heart
- Organ
- Loss of Movement or Consciousness

Benefit Separation Period (for reoccurrence of the same Covered Condition): 30 days

In addition to the Critical Illness Benefit Amount, a second Benefit equal to two times (2x) the Critical Illness Benefit Amount is payable for a reoccurrence of a specified Covered Condition, subject to the applicable Benefit Separate Period (as shown in this "Schedule Page"), and any non-reoccurring Covered Conditions. The sum of all Benefit payments for Covered Conditions shall not exceed two times the Critical Illness Benefit Amount. If the remaining balance of the second Critical Illness Benefit Amount is less than the amount payable for a Covered Condition as shown in this "Schedule Page", then a partial benefit payment will be made for that Covered Condition.

Benefit Waiting Period
30 days from the Insured Person's effective date

Critical Illness Benefit Amount after the Age Reduction
Insured: Benefits reduce to 50% of the Benefit Amount at age 70
Spouse: Benefits reduce to 50% of the Benefit Amount at age 70

Covered Conditions and Amounts - (accumulates towards the Critical Illness Benefit Amount)

Cancer
Invasive Cancer **100%**
Benign Brain Tumor **100%**
Bone Marrow Transplant **25%**

Heart
Heart Attack **100%**
Stroke **100%**
Aneurysm **25%**

Organ
End Stage Renal Disease **100%**
Major Organ Transplant **100%**

Loss of Movement or Consciousness
Coma **100%**
Paralysis **100%**

Health Screenings (Wellness) $50 per day (in one day increments)
Limit 1 health screenings per 12-month period. There is no waiting period for health screenings.

Exclusion
Pre-existing Condition Period: 12 months prior to effective date / 12 months after effective date

Definitions

Active Work and **Actively at Work** mean performing all the material duties of Your own occupation and satisfying the Minimum Hourly Work Requirement. Actively at Work includes regularly scheduled days off, holidays, or vacation days, so long as You are capable of sustained Active Work on those days. ↑

Aneurysm means a localized, blood-filled dilation of a blood vessel caused by disease or weakening of the vessel wall in the brain, carotid arteries or aorta and spilling blood into the surrounding tissues (a hemorrhage).

- The Diagnosis must be supported by medical records including radiographically specific studies, and including but not limited to, angiography, a CT or MRI scan, or an ultrasound.

Benefit Waiting Period means the time period (as shown in the "Schedule Page") an Insured Person must wait before Benefits are payable.

Benign Brain Tumor means a non-cancerous tumor. (Under this Certificate, Benign Brain Tumor excludes germanomas, pituitary adenomas or skull tumors.)

- The Diagnosis can be found by a CT or MRI brain scan.

Bone Marrow Transplant means a medical procedure performed to replace bone marrow damaged or destroyed by disease, infection or chemotherapy.

- The Diagnosis usually occurs after chemotherapy and radiation is completed.

Coma means a profound state of unconsciousness from which an Insured Person cannot be aroused to consciousness, even by external stimulation, lasting for a continuous period of at least 96 hours.

- The Physician's Diagnosis must indicate that permanent neurological deficit is present and is expected to last for a continuous 12-month period or longer from the date of the Diagnosis.

Contributory means You pay all or a portion of Your insurance premium.

Covered Condition means one of the Critical Illnesses listed in the "Schedule Page".

CT scan means a computerized tomography scan.

Diagnosed/Diagnosis means a definitive Diagnosis made by a Physician based upon the use of clinical and/or laboratory investigations as supported by an Insured Person's medical records and meeting any Diagnosis requirements set forth in this Certificate for the particular Critical Illness being Diagnosed.

- **Pathological Diagnosis** means Diagnosis of Invasive Cancer or Non-Invasive Cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. The Diagnosis of malignancy must conform to Pathology standards.

Eligible Class means a classification defined by the Group and shown in the "Schedule Page." You must be an Eligible Person of an Eligible Class in order to be eligible for this insurance.

Eligible Dependent (also referred to as "**Dependent**") means Your "Spouse" or "Child" (defined below) who is not in a Period of Limited Activity on their effective date of insurance or on any Increase of Insurance dates. Dependent does not include a person who is a full-time member of the armed forces of any country. No person may be considered a Dependent of more than one Insured Person. ***Period of Limited Activity*** *means any period of time a Dependent is confined in a hospital or nursing facility* .

- **Spouse** means a person to whom the Insured is married to and from whom the Insured is not separated. "Spouse" includes state recognized domestic partners.

- **Child** (Children) means Your unmarried "Child" until the age shown in the "Schedule Page". "Child" includes stepchild, foster child or legal ward, a Child legally placed in the home for adoption and/or a legally adopted Child. Except where otherwise specified, a Child of a state recognized domestic partner will be the equivalent of a Child of a Spouse under this Certificate.

  Disabled Child means Your unmarried adult "Child" who is, on and after the date the insurance would end because of the Child's age, continuously incapable of self-sustaining employment because of intellectual disability or physical disability and chiefly dependent upon You for support and maintenance. You must provide proof of Your Disabled Child's status within 31 days after the date insurance would otherwise end because of the Child's age. Thereafter, We may require further proof of Your Disabled Child's status, but not more often than annually after the 2-year period following the Child's attainment of the limiting age. Costs associated with such proof will be Your responsibility.

Eligible Person means an individual in an Eligible Class (as shown in the "Schedule Page"), who is Actively at Work, and who is reported on the Group's records for Social Security and tax withholding purposes.

EKG means an electrocardiogram.

End Stage Renal Disease means the last stage of chronic kidney disease. When kidneys fail they stop working well enough to survive without dialysis or a kidney transplant.

Group Effective Date means the date (shown in the "Schedule Page") the Group Policy, with respect to the Group, became effective.

Group Policy means the group insurance policy We issued to the Group.

Group and **Group Policyholder** mean the "Group Policyholder" named in the "Schedule Page".

Health Screenings means annual physicals; blood tests; x-rays; diagnostic imaging; EKG or echocardiogram; bone marrow screening; human papillomavirus vaccine; bone mass density measurement; skin cancer screening; thermography; ultrasounds; prostate-specific antigen test; pap smears; cytological screening; breast ultrasound; digital rectal exams; flexible sigmoidoscopy; stool analysis; colonoscopy; cancer antigen tests; child and adult immunizations; and hearing and vision screening services.

Heart Attack means an acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries, and which results in the loss of the normal function of the heart. (Under this Certificate, Heart Attack excludes established (old) myocardial infarctions.)

- The Physician's Diagnosis must be validated with an EKG and/or abnormal labs and treatment must occur within 72 hours of the onset of symptoms.
- In the event a Heart Attack results in death, a death certificate, indicating Heart Attack as the cause of death, is required.

Insured means an Eligible Person whose insurance is in effect under this Certificate.

Insured Person means an Insured or Eligible Dependent whose insurance is in effect under this Certificate.

Invasive Cancer means a malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Leukemias and lymphomas are included. (Under this Certificate, Invasive Cancer excludes pre-malignant lesions (such as intraepithelial neoplasia); benign tumors or polyps; early prostate cancer diagnosed as Stage 1 or equivalent staging; Non-Invasive Cancer; or any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).)

- The Diagnosis includes a positive confirmation of a Pathological Diagnosis upon the basis of a microscopic examination of fixed tissues, or preparations from the hematopoietic and lymphatic systems. The Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic structure or

pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard, unless the following conditions are met: (i) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening; (ii) there is medical evidence to support the Diagnosis; and (iii) a Physician is treating an Insured Person for Invasive Cancer and/or Non-Invasive Cancer.

Major Organ Transplant means clinical evidence of major organ failure which requires the malfunctioning organ(s) or tissue of an Insured Person to be replaced with an organ or tissue transplant from a suitable human donor under generally accepted medical procedures. The organ(s) and tissues are heart, kidney(s), bladder, liver, lung(s), stomach, intestines and pancreas.

- In order for the Major Organ Transplant Benefit to be paid under this Certificate, the Insured Person must be registered by the United Network of Organ Sharing or the National Marrow Donor Program.

Minimum Hourly Work Requirement means the work hours over a given time period required of You by the Group in order to be eligible for insurance. Your Minimum Hourly Work Requirement is shown in the "Schedule Page".

MRI means a magnetic resonance imaging scan.

Noncontributory means the Group pays the entire premium for insurance.

Paralysis means the complete and permanent loss of use of two or more limbs, through neurological injury, for a continuous period of at least 180 days. Neurological injury does not include Stroke.

- The Physician's Diagnosis must include documented evidence of the injury that caused the Paralysis. The uninterrupted 180-day period of Paralysis is waived if clinical and radiological evidence shows that the spinal cord has been transected with no possibility of returned functionality.

Physician means any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse, or registered nurse first assistant for treatment of any illness or injury within the scope and limitations of the person's practice. He or she must be properly licensed or certified by the laws of the state where he or she practices. For the purpose of this insurance, Physician does not include You or Your Spouse or the brother, sister, parent or child of either You or Your Spouse.

Pre-existing Condition means a physical condition, whether or not diagnosed, where an Insured Person did one or more of the following at any time during the Pre-existing Condition Period (shown in the "Schedule Page") just before his or her effective date of insurance or the effective date of any subsequent increase in insurance:

1. consulted a Physician or other licensed medical professional;
2. received medical treatment, services or advice; or
3. underwent diagnostic procedures, including self-administered tests (excluding blood) or procedures.

Prior Plan means the Group's group critical illness insurance in effect on the day immediately preceding the Group Effective Date under the Group Policy.

Special enrollment period (if applicable) means an enrollment period for Eligible Persons or Eligible Dependents to apply, subject to the "Special enrollment period" provision in section "Eligibility and Effective Dates".

Stroke means a cerebrovascular incident caused by infarction of brain tissue, cerebral or subarachnoid hemorrhage, cerebral embolism or cerebral thrombosis, persisting for at least 96 hours following the occurrence of the Stroke. (Under this Certificate, Stroke does not include transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.)

- The Physician's Diagnosis must be based on documented neurological deficits and confirmatory neuroimaging studies.

Waiting Period for insurance means the time period (as shown in the "Schedule Page") You must be an Eligible Person (and Actively at Work) before insurance is effective, unless You were insured under the Prior Plan.

We, Us and **Our** means Madison National Life Insurance Company, Inc.

You and **Your** means the Insured.

Eligibility and Effective Dates

Eligibility for Insurance

Eligible Person .

Your eligibility date is the first day of the month following Your Waiting Period for insurance.

To be eligible You must satisfy the following requirements:

1. be an Eligible Person.
2. be a citizen or legal resident of the United States of America or one of its territories or Canada.
3. satisfy Your Waiting Period for insurance, if any.
4. You cannot be an Eligible Person of more than one Eligible Class.
5. be Actively at Work and capable of sustained Active Work on the effective date of Your insurance and the effective date of any subsequent increase in insurance.
6. You cannot be inpatient confined in a hospital or similar facility and must be able to perform routine activities of daily living. This means You must perform the following acts without direct assistance or continuous help or oversight from someone else: (i) wash or bathe Yourself in the tub or shower, or by sponge bath from a basin; (ii) dress or change clothes, including fastening and unfastening any braces or artificial limbs; (iii) eat or feed Yourself once food has been prepared and made available; (iv) transfer Yourself or move in and out of a chair or bed except with the aid of equipment (including support and other mechanical devices); and (v) get to and from, and on and off, the toilet to maintain a reasonable level of personal hygiene and to adjust clothing.)
7. You cannot be a part-time, temporary, seasonal or leased worker; or a full-time member of the armed forces of any country.
8. You cannot be insured under more than one group critical illness policy.

Eligible Dependent

You must apply for Dependent insurance and Your Dependent must meet the definition of "Dependent". To be eligible an Eligible Dependent must satisfy the following requirements:

1. be an Eligible Dependent.
2. be a citizen or legal resident of the United States of America or one of its territories or Canada.
3. cannot be inpatient confined in a hospital or similar facility and must be able to perform routine activities of daily living. This means you must perform the following acts without direct assistance or continuous help or oversight from someone else: (i) wash or bathe yourself in the tub or shower, or by sponge bath from a basin; (ii) dress or change clothes, including fastening and unfastening any braces or artificial limbs; (iii) eat or feed yourself once food has been prepared and made available; (iv) transfer yourself or move in and out of a chair or bed except with the aid of equipment (including support and other mechanical devices); and (v) get to and from, and on and off, the toilet to maintain a reasonable level of personal hygiene and to adjust clothing.)
4. cannot be insured under more than one group critical illness policy.

Effective Dates

Initial Enrollment

Insured: Insurance is effective if You apply prior to or within 31 days of the date You become an Insured Person.

Dependents: Insurance is effective when You apply for Your Dependent(s) prior to or within 31 days of their eligibility date (e.g. marriage, newborn, adoption, or placement for adoption). Newborn Children are

automatically insured for the first 31 days from the moment of birth. If You do not apply within 31 days Your Dependent(s), including newborn Child, may not enroll until the next Annual or Special enrollment period.

Special enrollment period

This provision only applies if the Schedule Page indicates it is included.

If an Eligible Person or Eligible Dependent does not enroll when first eligible, he or she may enroll for insurance, other than at Annual enrollment, if at the time the Eligible Person or Eligible Dependent: (i) was insured by insurance providing similar critical illness benefits and (ii) lost that insurance for one or more of the following reasons:

1. termination of eligibility;
2. changes from full-time to part-time employment;
3. termination of the other insurance referenced above;
4. death of a Spouse; or
5. legal separation or divorce from a Spouse.

In addition, You may apply for a Dependent Spouse who becomes eligible by reason of marriage, or children who become eligible as shown in the definition of "Child", after Your effective date.

Increases in Insurance

An increase in insurance can only occur during a Special enrollment period or Annual enrollment period. An increase in insurance is effective on the first day of the month immediately following the month You are eligible for such insurance, except if You are eligible on the first day of a month, insurance is effective on that day.

Rules for Transfer of Persons from Prior Plan

Continuation of Insurance and Pre-existing Conditions. In calculating the insurance period for determining whether the Pre-existing Condition Exclusion applies, We include any period of continuous insurance under the Group's Prior Plan providing similar critical illness benefits, immediately preceding the date You became insured under this Certificate.

Leaves of Absence

Approved FMLA Leave of Absence

Contributory or Noncontributory Premiums: If You are on leave with the Federal Family and Medical Leave Act of 1993 (FMLA), as amended, insurance will continue until the later of the required FMLA leave period or the leave period required by applicable state law, if:

1. FMLA Leaves, and the right to continue insurance during FMLA Leaves, are available to all Insureds in the same Eligible Class under the Group Policy;
2. the Group remits the required insurance premium; and
3. the FMLA Leave is approved in advance by the Group and the approval includes documentation with the beginning and ending dates of the leave. Documentation about Your leave must be available to Us at Our request.

If You cease to be an Eligible Person and insurance ends, and then You again become an Eligible Person in all respects within 3 months, the Waiting Period for insurance will be waived on the first day of Your return to Active Work. If You become insured again the Pre-existing Condition Exclusion will apply as if there was no gap in insurance.

Critical Illness (Covered Condition) Benefit Payments

Critical Illness Benefits are payable for Diagnoses or procedures that occur after the Benefit Waiting Period, as shown in the Schedule Page, when an Insured Person has experienced a Critical Illness, been Diagnosed with a specific Critical Illness or undergone a specific procedure for a Critical Illness. **Critical Illness Benefits are payable until the maximum Critical Illness Benefit Amount, shown on the "Schedule Page", is reached.**

We may have the Critical Illness Diagnosis reviewed by a Physician of Our choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, We may request an examination of either the Insured Person, or the evidence used in arriving at such Diagnosis, by an independent acknowledged expert selected by Us in the applicable field of medicine.

Benefit Payments upon Diagnosis of a Critical Illness are subject to the following: (1) the Diagnosis is made within the United States; (2) the Diagnosis is made while the Insured Person's insurance is in effect under this Certificate; and (3) Benefits must not be precluded by any general or specific Certificate Exclusion or any failure to meet any condition precedent set out herein.

Exclusions

No Benefit is payable if the Critical Illness is caused by or contributed to:

1. war or act of war. War means a state or period of declared or undeclared war whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states or parties.
2. commission of a felony or being engaged in an illegal occupation for which the Insured person has been convicted.
3. an intentional self-inflicted injury or attempted suicide.
4. being confined in a penal or correctional facility, for any reason, due to being convicted of a crime.
5. being intoxicated during the commission of a crime where the Insured Person has been found guilty in a court of law;
6. under the influence of any narcotic, unless administered on the advice of a Physician.
7. a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition, unless the Insured Person has not received treatment for the Pre-existing Condition, for the time period shown in the "Schedule Page", after his or her effective date of insurance or an elected increase in insurance.
8. any treatment, service or supply where no charge is made or the Insured Person is not billed or is not required to pay.
9. any treatment, service or supply received by the Group Policyholder or a person who does not meet the definition of "Physician".
10. military service in the armed forces, or any active or reserve component including training duty, of any state or country.
11. any cosmetic surgery, or complications of cosmetic surgery, which: (i) does not promote the proper function of the body or prevent or treat a sickness or injury; or (ii) is directed at improving appearance, unless such surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or a disfiguring sickness or injury.
12. driving or riding in a motor-driven vehicle in a race, stunt show, speed test or while testing any vehicle on any race course or speedway.
13. voluntarily taking poison or inhaling gas.
14. the Insured Person's employment.
15. operating, learning to operate, serving as a crewmember on, or jumping from or falling from any aircraft including aircraft not motor-driven.

16. participating in any sporting event for pay or prize money.
17. handling or using an illegal weapon.
18. being involved in racing or speeding contests, endurance tests or acrobatic or stunt driving.
19. flying in an ultralight, hang gliding, parachuting or bungi-cord jumping, or by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere.

Claims Provisions

Notice of Claim
To file a claim for Benefits under this Certificate, You must provide Us with Proof of Loss sent to our address shown on this Certificate's cover page. Notice given by You, or on Your behalf, to Us with information sufficient to identify You, is deemed notice to Us. Notice should be made within 180 days after the loss. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

Claims Forms
Upon receipt of written notice of claim We will send You a Claim Form for filing Proof of Loss. If You do not receive forms within 15 days after giving notice You can send Us, without the Claim Form, written Proof of Loss.

Proof of Loss
"Proof of Loss" means satisfactory written proof to determine if a loss occurred for Benefits, not subject to any Exclusion, and meets all other conditions for Benefits. Proof of Loss includes any other information We reasonably require in support of a claim for Benefits.

Proof of Loss must be provided in writing to Us, at Your expense, within 90 days after the date of the loss, if reasonably possible. Proof of Loss must be provided no later than one year after expiration of that 90-day period. The time limits under this section shall not apply while the Insured Person lacks legal capacity.

Proof of Loss includes any items We reasonably require in support of a claim, such as completed claims statements and a signed authorization for Us to obtain information. If the required documentation is not provided within 45 days after You receive Our request, Your claim may be denied. The time period for Our decision will be tolled while We are waiting for You to provide the requested information. No Benefits will be paid until We receive Proof of Loss satisfactory to Us.

Physical Examination and Autopsy. We may examine, at Our own expense, an Insured Person when a claim is made and when and so often as We reasonably require during the pendency of the claim, and to request an autopsy in case of death, where it is not prohibited by law.

Claim Decision
We will notify You of Our claim decision within a reasonable period of time, but not later than 45 days after We receive Proof of Loss. If We request additional information from You to assist Us in making the claim decision, We will notify You of Our decision within 30 days after We receive the information.

We may extend these time periods up to 30 days if We determine an extension is necessary due to matters beyond Our control. We will notify You prior to the end of the initial 45-day period of the circumstances requiring the extension of time and the date We expect to render a decision.

If, prior to the end of the first 30-day extension period, We determine that due to matters beyond Our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days. We must notify You of the second 30-day extension period prior to the expiration of the first 30-day extension period.

In the case of an extension, the notice of extension will specifically explain the standards which entitlement to a Benefit is based. It will also explain the unresolved issues that prevent a decision on the claim, any additional information needed to resolve those issues, and the date We expect to render a decision.

Time of Payment of Claims and Payment of Claims
We will pay Benefits within 20 days after We receive Proof of Loss. Payment will be made in one lump sum to You or to the payee You appropriately assign. Payment of these Benefits will reduce the Insured Person's Critical Illness Benefit Amount under this Certificate.

Benefits are paid to You, as shown in the "Schedule Page. Indemnity for loss of life will be payable in accordance with the beneficiary designation in effect at the time of payment. If there is no designation or provision in effect, indemnities will be payable to the Insured Person's estate. Any other accrued indemnities unpaid at the Insured Person's death will be paid, at our option, either to beneficiary or to the Insured Person's estate. All other indemnities will be payable to the Insured. Any payment will fulfill Our responsibility for the amount paid. All other Benefits under this Certificate are payable to You.

Facility of Payment. We may pay part of the Benefit, up to $500, to any person appearing to Us to be equitably entitled to the amount by having incurred funeral or other expenses incident to the last critical illness or death of an Insured Person. Any Benefit payment made before Our home office received written notice of a valid claim, by some other person, releases Us from further obligation.

Notice of Adverse Decision on Claim
If We deny any part of Your claim You will receive a written notice of denial containing the following:

1. the specific reasons for Our decision;
2. specific reference to the provisions of this Certificate which Our decision is based;
3. a description of any additional information needed to perfect Your claim and an explanation of why the information is necessary;
4. information concerning Your right to appeal Our decision; and
5. if an internal rule, guideline, protocol or other similar criterion is relied upon in making the adverse decision, We will either provide a copy of the internal rule, guideline, protocol or other similar criterion or information as to how You may obtain a copy of it free of charge upon request.

Review Procedure
If all or part of a claim is denied You or Your authorized representative may request a review in writing and send Your request to Us within 180 days after You or Your authorized representative receive notice of the denial. You or Your authorized representative may send Us written comments or other items to support the claim. We will review the claim promptly after We receive the request. We will send You or Your authorized representative a notice of our decision within a reasonable time but not later than 30 days after We received the request in the case of a prospective review or 60 days after We received the request in the case of a retrospective review, unless special circumstances require an extension. If We determine that an extension in Our review time is required, written notice of the extension will be furnished to You or Your authorized representative prior to the expiration of the initial period. In no event will such extension exceed a period of 60 days from the end of the initial period, after We receive the required Proof of Loss.

When Insurance Ends

Insured Person
Except as otherwise provided for under this Certificate, insurance will cease on the earliest of the following to occur:

1. upon Your request;
2. the date the maximum Critical Illness Benefit Amount available under this Certificate has been paid for an Insured Person and no other Benefits are available;

3. the date You cease to be an Eligible Person or the premium due date on or next following the date You cease to be an Eligible Person.
4. the date a Dependent ceases to be an Eligible Dependent;
5. the date the Group Policy terminates; or
6. the date Your required premium payment is not paid.

Termination or Amendment of the Group Policy
The Group Policy may be terminated, changed or amended by Us or the Group according to the terms of the Group Policy. Any change or amendment may apply to Insureds or to any separate classes or categories thereof. We may change the Group Policy when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or with the Group's consent.

If We terminate this Group insurance according to the terms of the Policy, We will give the Group not less than a 90-day notice. A Group may terminate insurance under the Group Policy in whole or may terminate insurance for any class or group of Insureds, at any time by giving Us advanced written notice at least 60 days prior to termination. Insurance will terminate automatically for nonpayment of premium, subject to the Group Policy's grace period and reinstatement provisions.

Unpaid Premium. When a claim is paid under the Group Policy, any premium then due and unpaid for Your Certificate may be deducted by Us from the claim payment.

Reinstatement of Insurance
If Your insurance ends because You fail to make the required contribution while on an approved Family Medical Leave Act (FMLA) Leave of Absence, and then You return to Active Work and enroll in insurance within 31 days of the earlier of the end of the period of leave You and the Group agreed upon, or the end of the 12-week period following the date Your leave began, then the Benefit Waiting Period will be waived. If You are reinstated and a Pre-existing Condition Exclusion applies, it will apply as if there had been no gap in insurance.

General Provisions

Assignment
An Insured Person may assign his or her rights, privileges or Benefits under this Certificate, when approved by Us.

Clerical Error
Clerical error by Us, the Group, or their respective representatives will not: (i) cause a person to become insured under the Group Policy or a provision of it, (ii) invalidate insurance otherwise validly in force, (iii) continue insurance otherwise validly terminated, or (iv) cause a Group to obtain insurance under the Group Policy or a provision of it.

In the event that a clerical error results in an incorrect premium rate, We may adjust the premium rate accordingly. The payment of premium, by itself, does not obligate Us to provide Benefits to anyone who is not eligible for insurance under the Group Policy.

The Group acts on its own behalf as Your agent and not as Our agent. The Group has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

Conformity With Montana Statutes and Federal Laws
The provisions of this Certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Insured resides on or after the effective date of this Certificate.

Entire Contract, Changes
This Certificate, including the Enrollment Form, Group Policy and any Endorsement, amendment or rider, if any, constitutes the entire contract of insurance. No change in this Certificate shall be valid until approved by one of Our executive officers and unless approval is endorsed hereon or attached hereto. No agent has authority to change this Certificate or waive any of its provisions.

Legal Actions
No legal action may be brought to recover on this Certificate until at least 60 days after written Proof of Loss has been given as required. No legal action will be brought after the expiration of any applicable statutes of limitations.

Misstatement
If the age of an Insured Person has been misstated We will make an equitable adjustment of premiums, Benefits or both. The adjustment is based on the amount of insurance based on the correct age and the difference between the premiums paid or would have been paid if the age had been correctly stated.

Subject to the "Time Limit On Certain Defenses" provision, if an Insured Person's tobacco use has been misstated, We will make an equitable adjustment of premiums or Benefits, or both. The adjustment will be the amount of insurance based on the correct tobacco use and the difference between the premiums paid or would have been paid if the tobacco use had been correctly stated.

Time Limit On Certain Defenses
Insured Person: Any statement made to obtain or to increase insurance, in the absence of fraud, is a representation and not a warranty. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless We have given the Insured Person a copy of the written instrument he or she signed containing the misrepresentation.

- After insurance has been in effect for 2 years, during the lifetime of an Insured Person, We will not use a misrepresentation as a basis for reducing or denying a claim.

Group Policyholder: Any statement made by the Group to obtain the Group Policy, in the absence of fraud, is a representation and not a warranty. No misrepresentation by the Group will be used as a basis for denying the validity of the Group Policy, unless We have given the Group a copy of a written instrument signed by the Group, containing the misrepresentation.

- We will not contest the validity of the Group Policy after it has been in force for 2 years, except for nonpayment of premiums.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601

INSURANCE PORTABILITY BENEFIT ENDORSEMENT GROUP CRITICAL ILLNESS INSURANCE

This is an Insured Person's Insurance Portability Benefit Endorsement (hereafter referred to as "Endorsement"). **This Endorsement provides for an additional insurance benefit under the Group Critical Illness Certificate of Insurance** (hereafter referred to as "Certificate").

This Endorsement, including the Certificate, constitutes the Entire Contract of insurance. No change in this Endorsement shall be valid until approved by one of Our executive officers. No agent has authority to change this Endorsement or waive any of its provisions.

Provisions under this Endorsement are subject to all definitions, terms and conditions, limitations and exclusions of the Entire Contract, unless otherwise stated herein. Please refer to the Certificate.

When Your insurance ends under the Certificate because You cease to be an Eligible Person, You may elect to continue the insurance You had (including Dependent insurance) if You have been continuously insured for 12 months, under the Group Policy or its Prior Plan, just before Your insurance ended, and You are under the age of 60. Your insurance must end for a reason other than retirement or gross misconduct or You did not make Your required premium contribution. You must not be insured under any other group critical illness insurance and You must not be Disabled.

To continue Your insurance under the Certificate with this Endorsement, You must apply in writing and pay the first premium to Us within 31 days after the date Your insurance terminated. If You do not purchase portable insurance for Yourself You cannot purchase it for any Dependent, if applicable. You will receive further information when You purchase this portable insurance.

Your portable insurance is governed by the Group Policy and can be reduced or terminated. Insurance under this Endorsement will end the earlier of the date the Insured fails to pay any required premium, the Insured attains age 80, or the Group Policy terminates.

Executed by Madison National Life Insurance Company, Inc.

Marita Zuraitis
President

NOTICE OF PROTECTION PROVIDED BY MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The Association was established under Montana law to provide protection in the unlikely event that a life, annuity or health insurance issuer becomes financially unable to meet its obligations and is placed into liquidation. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies. In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate, and subject to the following maximum limits:

- Life Insurance
  - $300,000 in death benefits, but limited to $100,000 in cash surrender or net cash withdrawal values

- Health Insurance
  - $500,000 in health insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 present value, including net cash surrender and net cash withdrawal values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to the $500,000 maximum in health insurance benefits but not including disability, long term care or other types of health insurance benefits.

Note: Other restrictions to coverage apply. Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mtlifega.org or contact:

Montana Life and Health Insurance Guaranty Association
PO Box 8247, Missoula, MT 59807
1-877-678-1048 or administrator@mtlifega.org

Office of the Montana State Auditor, Commissioner of Securities and Insurance
840 Helena Ave.
Helena, MT 59601
1-406-444-2040

IF YOUR INSURANCE COMPANY IS IN GOOD STANDING AND NOT IN LIQUIDATION, PLEASE DIRECT QUESTIONS ABOUT YOUR POLICY TO YOUR INSURANCE COMPANY!

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

NOTICE

This notice describes identities of and relationships among the insurer, administrator, and policyholder/certificate holder of this insurance.

Insurer: The insurance underwriter of your policy/certificate of insurance is as follows:

Madison National Life Insurance Company, Inc. (MNL)
1241 John Q. Hammons Drive
Madison, WI 53717

Third Party Administrator (TPA): The TPA of your policy/certificate of insurance is as follows:

North American Benefits Company (NABCO)
20 Valley Stream Parkway, Suite 310
Malvern, PA 19355

NABCO provides administrative services for insurance issued to policyholders/certificate holders including, but not limited to, claims, underwriting, premium billing, premium collection, client service, contract and policy/certificate issuance.

There is no ownership affiliation between MNL and NABCO.

Policyholder/Certificate Holder: The policyholder/certificate holder is listed in the Schedule of Benefits.

The TPA administers the insurer's policy/certificates in accordance with all contract provisions and pays benefits to the policyholders/certificate holders. All rights and responsibilities of the parties are outlined in the policy/certificate.

Your policy/certificate is fully insured which means the covered risk(s) is the responsibility of the insurer whereas the risk of a self-insured policy/certificate is the responsibility of the employer or company.