MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

1241 John Q. Hammons Drive, Madison, WI 53717● PO Box 5008, Madison, WI 53705
(800) 356-9601 ● www.madisonlife.com

Critical Illness Insurance Certificate

The Policy has been issued to the Policyholder.

This Certificate of insurance is evidence of the Covered Person's coverage under the Policy and of its benefits. Everything contained in this Certificate is subject to the provisions, definitions, and exceptions in the Policy, if any. The Policy is on file with the Policyholder and may be examined at any reasonable time. Only one of Our executive officers may authorize a change to the Policy.

This Certificate replaces all certificates and certificate riders, if any, previously issued to the Primary Insured under the Policy. The Policy was delivered in the State of Issue and is governed by its laws and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

NOTICE OF RIGHT TO EXAMINE CERTIFICATE. If the Primary Insured is not satisfied with the Certificate for any reason, the Primary Insured may return it to Us within 30 days after it is received. Once returned, We will refund the premiums paid, and the Certificate will be voided from the Primary Insured's Coverage Effective Date.

This Certificate is signed for us by:

President and Chief Executive Officer

Executive Vice President and Corporate Secretary

THIS IS A CRITICAL ILLNESS CERTIFICATE. IT PROVIDES LIMITED BENEFITS. BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS CERTIFICATE CAREFULLY. THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF A COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON SHOULD REVIEW A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

CERTIFICATE INDEX GUIDE

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Madison National Life
a Horace Mann company

CERTIFICATE SCHEDULE PAGE

Policyholder:	West Des Moines CSD	**Certificate Issue Date:**	7/1/26
Policy Number:	013781GR2	**Types of Certificate Coverage:**	
Policy Effective Date:	July 1, 2026	Primary Insured	
Policy Anniversary:	July 1	Primary Insured and Spouse	
Policy State of Issue:	Iowa	Primary Insured and Child(ren)	
		Primary Insured and Family	

Eligible Class(es):

Class 1: All full-time employees that are Actively at Work for the Policyholder.

Eligibility Waiting Period 0 days

BENEFITS SCHEDULE

THIS IS ONLY A SUMMARY. SEE THE ACTUAL CERTIFICATE PROVISIONS FOR ADDITIONAL LIMITATIONS AND COMPLETE DETAILS.

1. Critical Illness Benefit

Critical Illness Benefit Amount

Primary Insured	$20,000
Spouse	$10,000
Child	$10,000
Lifetime Maximum	300% of Critical Illness Benefit Amount

Critical Illness	**Percentage of Critical Illness Benefit Amount Payable**
Invasive Cancer	100%
Non-Invasive Cancer (In Situ)	25%
Skin Cancer	$250
Heart Attack	100%
Stroke	100%
Sudden Cardiac Arrest	100%
Coronary Artery Disease	25%
Angioplasty	25%
Heart Valve Surgery	50%
Pulmonary Embolism	25%
Transient Ischemic Attack (TIA)	25%
End-Stage Renal Failure	100%
Major Organ Failure	100%
Benign Brain Tumor	100%
Coma	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Major Burns	100%
Permanent Paralysis	100%
Stem Cell/Bone Marrow Transplant	25%
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS)	100%

2. Recurrence Benefit

Primary Insured	100% of initial benefit paid
Spouse	100% of initial benefit paid
Child	100% of initial benefit paid

3. Additional Occurrence Benefit

Same as initial benefit amount applicable to the Critical Illness

4. Wellness Benefit

A. Wellness Benefit $50/Calendar Year

5. Waiver of Premium Benefit

Begins on 91st day of Total Disability of the Primary Insured, if under age 60.

CONDITIONS OF COVERAGE

Eligibility

Each person that is a member of an Eligible Class is eligible for coverage under the Policy as a Primary Insured, subject to any Eligibility Waiting Period shown on the Certificate Schedule. Coverage may also be extended to include the Primary Insured's Dependent(s) based on the provisions below.

Primary Insured's Effective Date

We have issued this Certificate in consideration of: (1) authorization of the required premium; (2) the Primary Insured's enrollment form (if required); and (3) the Primary Insured's evidence of insurability (if required). If evidence of insurability is required, coverage is not effective until We approve the Primary Insured's request for coverage. The Primary Insured's coverage begins on the Primary Insured's Coverage Effective Date at 12:01 A.M. Standard Time at the address where the Policy was delivered.

An eligible person may enroll only within 31 days after becoming eligible or acquiring a new Dependent or during an open enrollment period.

Dependent's Effective Date

Insurance for a Dependent that is eligible on the Primary Insured's Coverage Effective Date is effective on that date, provided the Primary Insured enrolls the Dependent, and the required premium is authorized. Otherwise, a Dependent's insurance becomes effective at 12:01 A.M. Standard Time at the address where the Policy was delivered on the Dependent's Coverage Effective Date, provided the Primary Insured enrolls the Dependent and the required premium has been authorized.

In no case will coverage for eligible Dependents take effect before the Primary Insured's coverage. Evidence of insurability may be required. If required, coverage will not be effective until We approve the Dependent's request for coverage.

A person may not be covered under the Policy as both a Primary Insured and a Spouse. The Primary Insured may not apply for coverage for the Primary Insured's spouse if the spouse is covered under the Policy as a Primary Insured. If the Primary Insured and spouse are both covered under the Policy as Primary Insureds, any Child(ren) may be covered under one of the parent's plans, but not both.

Newborn Child Coverage

A child of the Primary Insured born while the Primary Insured's coverage under the Policy is in force is covered from the moment of birth until the 31st day of age. If any additional premium is required, a notice of birth, together with the additional premium, must be submitted to Us within 31 days of birth to continue coverage beyond the initial 31 day period.

Adopted Child Coverage

A minor child who comes under the charge, care and control of the Primary Insured while the Primary Insured's coverage under the Policy is in force is covered if the Primary Insured files a petition to adopt. The child's coverage is the same as provided for the Primary Insured's other Dependent(s). The child is covered from the date the petition to adopt is filed if the Primary Insured applies for coverage and pays any required premium within 31 days after filing the petition to adopt. However, coverage starts at the moment of birth if the petition for adoption, application for coverage and payment of premium occur within 31 days after the child's birth. Coverage for the minor child continues, unless the petition for adoption is dismissed or denied.

Foster Child Coverage

A child placed with the Primary Insured as a foster child while the Primary Insured is covered under the Policy is covered from the date of placement. If any additional premium is required, a notice of placement as a foster child together with the additional premium must be submitted to Us within 31 days after the date of such placement to continue coverage beyond the 31-day period.

Medical Support Order

A child who is the subject of a medical support order is covered under the Policy when We receive notice of the medical support order. If any additional premium is required, it must be submitted to Us within 31 days after the date of the notice to continue coverage beyond the 31-day period.

Deferred Effective Date

All Coverage Effective Dates will be deferred if the Primary Insured is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the first day of the month following the day after the date the Primary Insured has completed one full day of Active Work, except that coverage will become effective on the first day of the current month if these requirements are met on that date.

Other Insurance With Us

A Covered Person cannot be covered under more than one of Our Critical Illness policies at a time. If we issue more than one such policy, the Primary Insured must select one of the Covered Person's coverages to cancel. If the cancellation results in a decrease in the required premium payment, We will refund the premiums paid for the cancelled coverage for the time duplicate coverage was in effect. If the Primary Insured does not select one coverage to cancel, we will automatically cancel the Covered Person's coverage purchased most recently.

PREMIUM PROVISIONS

Payment of Premiums

If the Primary Insured is responsible for paying premiums directly to Us, such premiums may be paid to Us at Our Home Office. The first premium is due on or before the Primary Insured's Coverage Effective Date. All subsequent premiums are due on the premium due date. The premium for additional, increased, reduced, or terminated insurance may cause a pro-rata adjustment on the next premium due date.

Premium Changes

After the initial premium rates have been in effect for 24 months from the Policy Effective Date, We may recalculate premium rates. We also have the right to recalculate the initial or any subsequent premium rate when the terms of the Policy or Certificate change.

If the Primary Insured is responsible for paying premiums directly to Us, We will give the Primary Insured 60 days advance written notice of any change in premium rates. We will not change the rates more than once in any period of 12 consecutive months.

Grace Period

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium. During the Grace Period, the coverage offered under this Certificate shall continue in force unless the Primary Insured gives Us written notice of termination in advance of the date of termination and in accordance with the terms of this Policy. If the entire premium is not paid by the end of the Grace Period, the coverage provided by this Certificate will terminate.

Reinstatement

If any renewal premium is not paid within the time granted the Primary Insured for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate the Covered Person's coverage. However, if We or Our agent require an application for reinstatement, the Covered Person's coverage will be reinstated upon the earlier of the approval of the application by Us, or the 45th day following the date the premium was received by Us, unless We have previously notified the Primary Insured in writing of Our disapproval of the application.

The reinstated insurance shall cover only loss that is Diagnosed more than 10 days after the date of reinstatement. In all other respects, all parties shall have the same rights as under the Policy immediately before the due date of the defaulted premium, subject to the provisions of any Rider which may be attached in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Return of Premium

In the event of termination of the Primary Insured's coverage, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Primary Insured shall promptly pay, on a pro-rata basis, the unpaid earned premium, if any.

TERMINATION OF COVERAGE

Primary Insured's Termination

Coverage for the Primary Insured ends, subject to any continuation, portability, or conversion privileges (if available), on the earliest of:

1. the date the Policy terminates;
2. the last day of the month following the date the Primary Insured is no longer part of an Eligible Class, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid;
3. any premium due date, if full payment is not made when due, subject to the Grace Period provision;
4. the last day of the month following the date the Primary Insured attains age 70;
5. the date the Primary Insured enters an armed service on full-time active duty. Premium will be returned on a pro-rata basis if the Policyholder notifies Us in writing;
6. the date the Primary Insured requests coverage be terminated; or
7. the date of the Primary Insured's death.

The Policy will remain in force for any period for which the premium is paid when due or during the Grace Period. If the Policy terminates due to nonpayment of premium, it will terminate on the Renewal Date at 12:01 A.M. Standard Time at the address where the Policy was delivered (subject to the Grace Period provision).

Termination of coverage under the Policy will not affect a claim that existed on the date of termination.

Dependent's Termination

Coverage for Dependents ends, subject to any continuation, portability, or conversion privileges (if available), on the earlier of:

1. the Primary Insured's termination date;
2. the date We receive the Primary Insured's written request to terminate coverage under the Policy for such Dependent; or
3. the date the Dependent is no longer eligible, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid.

In no case will Dependent coverage end later than the Primary Insured's coverage. Termination of coverage under the Policy will not affect a claim that existed on the date of termination.

CONTINUATION PRIVILEGE

Primary Insured Continuation

If the Primary Insured is no longer part of an Eligible Class, coverage may be continued when loss of eligibility is the result of one or more of the following:

1. illness or injury;
2. a temporary leave of absence or furlough, which is approved by the Policyholder in writing;
3. a disability that renders the Primary Insured unable to perform the regular duties of the Primary Insured's occupation and is eligible for disability insurance as a result;
4. is laid off by the Policyholder as a result of downsizing or other strategic business decision unrelated to the Primary Insured's job performance;
5. the Family Medical Leave Act (FMLA).

Coverage continued under this provision will end on the next premium due date following the earliest of:

1. 12 weeks from the date the Primary Insured ceased to be part of an Eligible Class, unless the continuation is triggered by a leave of absence in accordance with the FMLA, in which case coverage will continue for the statutorily prescribed duration;
2. the date the Primary Insured is reinstated as part of an Eligible Class; or
3. the date the Primary Insured begins full-time employment with an employer other than the Policyholder.

If coverage is continued under this provision and premiums are not paid when due, coverage will terminate. Coverage continued under this provision will also end in accordance with the Termination of Coverage provisions. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

PORTABILITY PRIVILEGE

The Primary Insured may be eligible for portability coverage when coverage ends under the Policy. The terms, conditions, and premium rates of the portability coverage will be governed by a separate portability policy and may not be the same as those under this Certificate.

Primary Insured Portability

If the Primary Insured is age 64 or younger, the Primary Insured may request portability coverage when:

1. the Primary Insured is no longer part of an Eligible Class and is not eligible for coverage under the Continuation of Coverage provision in this Certificate;
2. the Primary Insured is no longer employed by the Policyholder; or
3. the Policy terminates and the Policyholder does not obtain a replacement Policy with another insurance carrier within 31 days.

Electing Portability

To elect portability coverage, the Primary Insured must send a request to Us. The benefits and premium rates of the portability coverage will be provided along with Our portability request form, which can be obtained by contacting the Policyholder or Us. The initial premium due must be received within 31 days after insurance under the Policy ends.

The continued group insurance portability coverage is available as a result of portability rights that arise solely from the Policy, as arranged for the Primary Insured as an employee welfare benefit, subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

BENEFITS

Subject to the terms, conditions, and exclusions and limitations of the Certificate, and upon proof of loss, We will pay the benefits described below. Diagnosis, care, or treatment must be made or received while the Covered Person is covered under this Certificate for benefits to be payable. The benefit amounts and any applicable maximums payable for each benefit are shown in the Benefits Schedule, unless otherwise stated in the benefit itself.

1. CRITICAL ILLNESS BENEFIT

The Critical Illness Benefit will be paid, as shown in the Benefits Schedule, if a Covered Person is Diagnosed with a Critical Illness. The benefit payable is based on a percentage of the Critical Illness Benefit Amount in effect for the Covered Person, unless otherwise noted in the Benefits Schedule. The total payable for all Critical Illness Benefits, including any Recurrence Benefits and Additional Occurrence Benefits, may not exceed the Lifetime Maximum Benefit shown in the Benefits Schedule.

A benefit is payable once for a specific Critical Illness. A Recurrence Benefit may be payable if the same critical illness is subsequently Diagnosed.

If a Covered Person is Diagnosed with two or more Critical Illnesses on the same day, only one benefit is payable. The single benefit paid will be for the Critical Illness that provides the largest benefit amount. If the benefit amounts are equal, the benefit paid will be for the Critical Illness selected by the Primary Insured.

2. RECURRENCE BENEFIT

The Recurrence Benefit will be paid, as shown in the Benefits Schedule, if a Covered Person is Diagnosed with a Critical Illness for which they previously received benefits under the Critical Illness Benefit. The following conditions must be satisfied:

1. The subsequent Diagnosis must be made while coverage is in force for the Covered Person under this Certificate. Worsening of a condition will not be treated as a subsequent Diagnosis for purposes of this benefit.
2. The Recurrence of the Critical Illness must be Diagnosed at least 180 days after the date of Diagnosis of the Critical Illness for which the benefit was previously paid.
3. The Critical Illness may not be excluded by name or specific description.
4. In the case of Invasive Cancer or Non-Invasive Cancer, the Covered Person must not have received Treatment for Invasive Cancer or Non-Invasive Cancer during the 180 day period noted above. For the purposes of this benefit, Treatment does not include Maintenance Drug Therapy or routine follow-up office visits to verify if the cancer has returned.

The Recurrence Benefit is not available for Transient Ischemic Attack (TIA) and Skin Cancer, which are payable only once per Covered Person.

The Recurrence Benefit is payable only 2 times for each Covered Person. There is no limit on the number of Recurrence Benefits payable.

3. ADDITIONAL CRITICAL ILLNESS BENEFIT

The Additional Critical Illness Benefit will be paid, if, after a Critical Illness Benefit for one Critical Illness is paid, the Covered Person is Diagnosed with a different Critical Illness. The following conditions must be satisfied:

1. The subsequent Diagnosis must be made while coverage is in force for the Covered Person under this Certificate.
2. The subsequent condition occurs and is Diagnosed at least 180 days after the date of Diagnosis for the most recently Diagnosed Critical Illness.
3. The subsequent condition is not excluded by name or specific description.

4. WELLNESS BENEFIT

A. Wellness Benefit.

We will pay the benefit amount shown in the Benefits Schedule if a Covered Person undergoes or receives documented services for any individual or combination of the following screening exams: abdominal aortic aneurysm ultrasonography, blood test for lipids including total cholesterol, LDL, HDL, and triglycerides, bone marrow testing, bone density screening, breast ultrasound or mammography, CA15-3 blood test for breast cancer, CA 125 blood test for ovarian cancer, carotid doppler, CEA blood test for colon cancer, chest x-ray, colonoscopy, electrocardiogram, double contrast barium enema, fasting blood glucose test, flexible sigmoidoscopy, hemoccult stool analysis, mammogram, pap smear, (including ThinPrep), PSA, serum cholesterol test to determine level of HDL and LDL, serum protein electrophoresis (blood test for myeloma), stress test, thermography, CT angiography, Testicular Ultrasound, Smoking Cessation Program, Cancer Genetic Mutation Test (BRCA), Skin Cancer Screening, Biopsies for Cancer, immunizations, and Lymphocyte Genome Sensitivity Test (LGS) (universal blood test for cancer).

Screening tests must be rendered by a Medical Practitioner while the Covered Person is covered under this Certificate. This benefit is payable only once per Calendar Year for each Covered Person.

5. WAIVER OF PREMIUM BENEFIT

If the Primary Insured becomes Totally Disabled for more than 90 days as the result of a Critical Illness which is Diagnosed after the Primary Insured's Coverage Effective Date, we will waive the premiums that fall due for this Certificate and any attached Riders until the earliest of the following occurs: (1) the Primary Insured is no longer Totally Disabled or (2) 24 months. The Total Disability must begin before the Policy Anniversary following the Primary Insured's 60th birthday. Upon approval of this benefit, waiver of premium will begin on the Renewal Date next following 90 days of continuous Total Disability. The premium must be paid during this waiting period. Once the Total Disability ends for at least 30 days, any future Total Disability will be considered a new period of Total Disability. After the period of Total Disability ends for which premiums have been waived, the Primary Insured's coverage will continue in force by timely payment of premiums as they become due. This benefit does not apply to the disability of a Spouse or Child insured under this Certificate.

CLAIM PROVISIONS

Notice of Claim

Notice of claim must be given to Us within 30 days after the occurrence or commencement of any loss covered by the Policy and evidenced by this Certificate, or as soon thereafter as reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, at Our Home Office with information sufficient to identify the Covered Person, shall be deemed notice to Us.

Failure to give notice within this time frame will not invalidate nor reduce any claim.

Claim Forms

Upon receipt of a Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proof of loss. If forms are not furnished within 15 days after the giving of notice, the claimant shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submission of, within the time fixed in the Certificate for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us, or to Our authorized agent, at Our Home Office within 90 days after the date of the loss. Failure to furnish proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within that time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Benefits payable under this Certificate, except for benefits that provide periodic payment, will be paid immediately upon Our receipt of due proof of loss. A benefit that is payable by periodic payments, subject to due written proof of loss, will be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

All benefits are payable to the Primary Insured. Any benefits unpaid at the time of the Covered Person's death will be paid to the Covered Person's designated beneficiary(ies) or if none, then to the Covered Person's estate.

Beneficiary Designation

The Primary Insured can designate one or more beneficiaries to receive any benefits under this Certificate that are unpaid at the time of a Covered Person's death. Beneficiary records will be kept by the Policyholder or the office/system where beneficiary records for the Policy are kept.

Change of Beneficiary

Unless the Primary Insured makes an irrevocable designation of beneficiary, the Primary Insured reserves the right to change the designated beneficiary. The consent of the beneficiary or beneficiaries shall not be required to surrender or assign the Policy, to change beneficiary or beneficiaries, or to any other changes in the Policy.

GENERAL PROVISIONS

Entire Contract

The Policy, including any endorsements, amendments and Riders, the Policyholder application which is attached to the Policy when issued, Covered Person enrollment forms and the Certificate(s) issued comprise the entire contract between the parties.

Time Limit on Certain Defenses

No statement made by any Covered Person, unless fraudulent, shall be used to contest the validity of the insurance after the insurance has been in force for two years prior to the contest. We may not contest any statement unless the statement is in writing and signed by the Covered Person. This provision shall not preclude Us from asserting at any time a defense based upon the Covered Person's ineligibility for coverage under this Certificate or upon any other provision in the Policy or Certificate.

Statements

All statements made by the Policyholder or any Covered Person shall be deemed representations and not warranties, and no such statements shall be used in the defense of a claim unless a copy of the instrument containing the statement is or has been furnished to the Covered Person or, in the event of the death or incapacity of the Covered Person, to the individual's beneficiary or personal representative.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Covered Person when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Overpayments

We have the right to recover any overpayments due to fraud and any error We make in processing a claim. The Primary Insured must reimburse Us in full. We will determine the method by which the repayment is to be made.

Unpaid Premium

Any unpaid premium due for a Covered Person's coverage under this Certificate may be recovered by Us by offsetting against amounts otherwise payable under this Certificate.

Legal Actions

No legal action may be brought to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be given.

Workers' Compensation

The Policy is not a Workers' Compensation policy. It does not replace nor satisfy any requirement for coverage by Workers' Compensation insurance.

Misstatement of Age

If the age of a Covered Person has been misstated, We may adjust premiums or benefit amounts to reflect the coverage that would have been provided for the correct age.

Conformity With State Statutes

Any provision of this Certificate which, on the Primary Insured's Coverage Effective Date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such state.

EXCLUSIONS AND LIMITATIONS

Benefits are only payable for any disease or condition that is Diagnosed when the Covered Person's insurance under this Certificate is in force. In addition, no benefit is payable for:

1. any condition not specifically named or described in the Benefits section or the Benefits Schedule;
2. a disease or condition caused or contributed to by:
    a. another Critical Illness, a complication of another Critical Illness, or Treatment of another Critical Illness for which the Covered Person has been paid a benefit under this Certificate;
    b. declared or undeclared war or act of war;
    c. committing or attempting to commit a felony or illegal occupation;
    d. the Covered Person's active participation in a riot or insurrection;
    e. intentionally self-inflicted injury;
    f. full-time active duty as a member of the armed forces of any country or international authority;
    g. the Covered Person's intoxication or being under the influence of drugs or any narcotic, unless prescribed by or administered by a Medical Practitioner;
    h. alcoholism or drug addiction;
3. services for which no charge is normally made in the absence of insurance;
4. Diagnosis or Treatment provided by a Family Member; or
5. Diagnosis received outside of the United States and its possessions, or Canada.

Eligibility Waiting Period

A person that is part of an Eligible Class must satisfy the Eligibility Waiting Period shown in the Certificate Schedule before becoming eligible for coverage under this Certificate.

Credit toward the Eligibility Waiting Period will be given for any period of time a Primary Insured was in an Eligible Class under a Prior Policy.

DEFINITIONS

This section provides the meaning of special or capitalized terms used in this Policy.

Actively at Work *or* ***Active Work*** means that a Primary Insured is:

1. performing all the regular duties of the Primary Insured's occupation for the Policyholder in the usual way for 30 or more hours each week; and
2. receiving compensation from the Policyholder for work performed.

A person is considered Actively at Work any day that is not that person's regular scheduled workday (e.g., vacation, holiday, or sick day) as long as the person was Actively at Work on the person's last preceding regular scheduled workday.

Activities of Daily Living means:

1. Bathing: washing oneself by sponge bath or in the tub or shower, including the task of getting into or out of the tub or shower;
2. Dressing: putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs;
3. Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously;
4. Transferring: moving into and out of bed or a wheelchair;
5. Toileting: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
6. Continence: the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

Advanced Alzheimer's Disease means a progressive degenerative disease of the brain that is Diagnosed as Alzheimer's Disease by a Medical Practitioner who is a psychiatrist or neurologist. The Covered Person must:

1. exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
2. be certified by a Medical Practitioner as requiring substantial physical assistance from another adult to perform at least 2 Activities of Daily Living.

The date of Diagnosis for Advanced Alzheimer's Disease is the date a Medical Practitioner certifies that the Covered Person is incapacitated due to Alzheimer's Disease and requires substantial physical assistance from another adult to perform at least 2 Activities of Daily Living. We will not pay benefits for Advanced Alzheimer's Disease if the Covered Person was Diagnosed with Alzheimer's Disease, regardless of the Covered Person's symptoms or incapacities, prior to the Covered Person's effective date of coverage.

Advanced Parkinson's Disease means a brain disorder that is Diagnosed as Parkinson's Disease by a Medical Practitioner who is a psychiatrist or neurologist. The Covered Person must:

1. exhibit 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement or sluggishness of physical and mental responses); and
2. be certified by a Medical Practitioner as requiring substantial physical assistance from another adult to perform at least 2 Activities of Daily Living.

The date of Diagnosis for Parkinson's Disease is the date a Medical Practitioner certifies that the Covered Person is incapacitated due to Parkinson's Disease and requires substantial physical assistance from another adult to perform at least 2 Activities of Daily Living.

We will not pay benefits for Advanced Parkinson's Disease if the Covered Person was Diagnosed with Parkinson's Disease, regardless of the Covered Person's symptoms or incapacities, prior to the Policy Effective Date of coverage.

Amyotrophic Lateral Sclerosis (ALS) means a motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

Angioplasty means Diagnosis of coronary artery disease requiring the Covered Person to undergo an Angioplasty procedure in order to mechanically widen narrowed or obstructed arteries or atherectomy procedure to remove plaque from a coronary, carotid or vertebral artery. The surgical requirement is waived if the Covered Person is too ill to undergo an Angioplasty or atherectomy, but the procedure would otherwise be recommended due to the severity of the coronary artery disease.

Benign Brain Tumor means a non-malignant tumor that is located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland. The tumor must require surgery or radiation Treatment or cause irreversible objective neurological deficits.

Benign Brain Tumor does not include: tumors of the skull; pituitary adenomas less than 10mm; or germinomas.

The date of Diagnosis for Benign Brain Tumor is the date a Medical Practitioner determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Calendar Year begins on the Primary Insured's Coverage Effective Date and continues through December 31 of that year; thereafter, January 1 through December 31.

Certificate means this document, which explains the insurance benefits provided, to whom and how benefits are payable, and limitations and exclusions that apply to coverage.

Certificate Issue Date means the effective date of this Certificate, which is shown on the Certificate Schedule Page.

Child or Children means:

1. the Primary Insured's children by birth;
2. the Primary Insured's adopted children;
3. the Primary Insured's stepchildren at the time of the application for coverage of the stepchildren; and
4. children for whom the Primary Insured is legally obligated to provide medical support.

Additionally, a Child meeting the criteria of any of the categories listed above must also be:

1. unmarried; and
2. either under age 27 or legally incapacitated and unable to be self-supporting because of a medically ascertainable mental or physical handicap.

Proof of incapacity must be given at the time of enrollment if the Child is then incapacitated and older than age 26. If the incapacity occurs after the enrollment is completed, proof of incapacity must also be provided if the incapacity persists after the Child's 27th birthday. We reserve the right to require additional proof that the Child is still incapacitated and dependent on the Primary Insured. After 2 years of continuous incapacity, we will not require such proof more often than once each year.

Coma means a state of profound unconsciousness from which a Covered Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Medical Practitioner. The Coma must be Diagnosed after the effective date of coverage and last for a period of 15 days. Coma does not include a medically induced coma.

Common Carrier means a commercial airline, train, bus, railway, boat or ship that operates on a regularly scheduled basis as a passenger carrier between predetermined points or cities. Taxis and privately chartered vehicles are not Common Carriers.

Confined or Confinement means a stay in a Hospital that is expressly billed:

1. as an inpatient confinement; or
2. on an hourly basis for twenty four or more continuous hours.

The requirement that the Covered Person be billed is not applicable in government Hospitals where there is no charge for services. In such an instance, documentation from the Hospital is required confirming either parts 1 or 2 shown above.

Coronary Artery Disease means coronary artery disease requiring the Covered Person undergo open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. It does not include disease requiring less invasive procedures such as, but not limited to balloon Angioplasty, laser relief, stents or other nonsurgical procedures. This surgery requires placement of the patient on a cardiac pulmonary bypass machine. The surgical requirement is waived if the Covered Person is too ill to undergo surgery, but bypass surgery would otherwise be recommended due to the severity of the coronary artery disease.

Coverage Effective Date for a Covered Person means the later of: (1) the first day of the month following the date the Primary Insured becomes eligible and satisfies all of the requirements found in the "Conditions of Coverage" section except that the Coverage Effective Date will be the first day of the current month if the requirements of coverage are satisfied on that date. (2) the first day of the month following the date we approve any additional Covered Persons under the "Conditions of Coverage" section; or (3) the first day of the month following the date we approve a reinstatement as to a Covered Person, except that the Coverage Effective Date will be the first day of the current month if reinstatement is approved on that date.

Covered Person means the Primary Insured and any Dependent(s) who are currently covered under the Policy and this Certificate.

Critical Illness means any of the conditions listed in the Critical Illness Benefits section of the Benefits Schedule.

Dependent(s) means a Primary Insured's Spouse and Child(ren).

Diagnosis, Diagnosed means a Medical Practitioner has definitively identified a disease or irregularity in a Covered Person. Such Diagnosis must:

1. be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the Covered Person's medical records; and
2. meet all diagnostic requirements stated in this Certificate for the particular condition being Diagnosed.

Eligibility Waiting Period means the continuous period of time an individual must be a member in an Eligible Class before becoming eligible for coverage under the Policy. The Eligibility Waiting Period begins on the date the individual becomes a member of an Eligible Class.

End-Stage Renal Failure means irreversible failure of both kidneys:

1. requiring a Covered Person to undergo regular hemodialysis or peritoneal dialysis at least weekly; or
2. for which a kidney transplant is recommended by a Medical Practitioner. The surgical requirement is waived if the Covered Person is too ill to undergo surgery, but surgery or placement on the United Network of Organ Sharing (UNOS) list (or comparable list) would otherwise be recommended due to the organ failure.

Family Member means a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Grace Period means the 31-day period after the Renewal Date. Please refer to the *Grace Period* provision.

Heart Attack means a myocardial infarction, coronary thrombosis, or coronary occlusion which:

1. results in the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries; and
2. is evidenced by new electrocardiographic changes and an elevation in cardiac enzyme levels.

Heart Valve Surgery means a disease of the heart that requires a cardiac surgery procedure in which a patient's mitral or aortic or both valves are replaced by a different valve.

Home Office means the primary corporate office of Madison National Life Insurance Company, Inc. at PO Box 5008, Madison, Wisconsin 53705 or such other location designated by us in writing to the Policyholder.

Hospital means an institution legally licensed that:

1. provides diagnostic, medical, and surgical treatment to sick or injured persons on an inpatient basis (or has such surgical facilities available on a prearranged contractual basis);
2. provides 24-hour nursing care by or under the supervision of a Nurse; and
3. is under the supervision of at least one licensed Medical Practitioner practicing within the scope of such Medical Practitioner's license.

Hospital does not include a: Hospice; rehabilitation facility; convalescent, nursing or rest home; home for the aged; facility for the care or treatment of drug addiction or alcoholism; hotel units, residential annexes or nurse administered units in or associated with a hospital; or special ward, floor, or other accommodation for: (1) convalescent, nursing, rehabilitation, ambulatory, or extended care, or (2) the care or treatment of drug addiction or alcoholism.

Invasive Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of neighboring tissue, including leukemia, lymphoma, sarcoma and multiple myeloma, unless otherwise excluded below. The disease must be supported by histological evidence of malignancy. Clinical Diagnosis of Invasive Cancer will be accepted when a pathological Diagnosis cannot be made, provided medical evidence substantially documents the Diagnosis of Invasive Cancer.

Invasive Cancer does not include:

1. Non-Invasive Cancer (In Situ);
2. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic;
3. pre-malignant lesions (such as intraepithelial neoplasia); or
4. benign tumors or polyps.

Loss of Hearing means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The date of Diagnosis for Loss of Hearing is the date the Medical Practitioner makes a certification of total permanent hearing loss.

Loss of Sight means the total and irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes or the field of vision being less than 20 degrees in both eyes.

The date of Diagnosis for Loss of Sight is the date a Medical Practitioner makes a certification of total and permanent blindness.

Loss of Speech means the total and irreversible loss of the ability to speak or communicate verbally without the assistance of a medical device. The date of Diagnosis for Loss of Speech is the date a Medical Practitioner makes a certification of total and permanent loss of speech.

Maintenance Drug Therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer reoccurrence rather than the palliation or suppression of a cancer that is still present.

Major Burns means a Covered Person has sustained third degree burns covering at least 20% of the surface area of the Covered Person's body.

Major Organ Failure means failure or loss of one or more of the following organs: kidney, liver, heart, lung or pancreas, requiring a surgical transplant of a human organ. It does not include transplants involving mechanical or nonhuman organs. The surgical requirement is waived if the Covered Person is too ill to undergo surgery, but surgery or placement on the United Network of Organ Sharing (UNOS) list (or comparable list) would otherwise be recommended due to the organ failure.

Medical Practitioner means a medical professional who is:

1. duly licensed by the state in which such professional practices medicine; and
2. acting within the scope of such professional's medical license.

Medical Practitioner does not include a Covered Person or a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Non-Invasive Cancer (In Situ) means a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Non-Invasive Cancer (In Situ) includes:

1. chronic lymphocytic leukemia that has not progressed beyond RAI Stage 0;
2. stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion); or
3. early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis.

Non-Invasive Cancer (In Situ) does not include:

1. skin cancer other than non-invasive malignant melanoma or stage 1A (T1a) malignant melanoma;
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. benign tumors or polyps.

Nurse means a Registered Nurse (R.N.); a Licensed Practical Nurse (L.P.N.); or a Licensed Vocational Nurse (L.V.N.). Nurse does not include a Covered Person or a Covered Person's spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children or grandchildren.

Permanent Paralysis means damage to the brain or spinal cord that results in quadriplegia, paraplegia, hemiplegia, or diplegia (complete and total loss of use or loss of movement of two or more limbs) Diagnosed by the Covered Person's attending Medical Practitioner.

Policy means the insurance contract issued to the Policyholder under the Policy Number shown in the Certificate Schedule. The Policy includes the Certificate and any amendments, Riders, endorsements or other papers attached.

Policyholder means the entity to which the Policy is issued.

Primary Insured means an individual who is:

1. part of an Eligible Class; and
2. currently covered under the Policy and this Certificate.

The Primary Insured has the right to make all changes to the Certificate and receive benefits described in this Certificate.

Prior Policy means group critical illness insurance issued to the Policyholder or an employer acquired by the Policyholder on the day before the Policy Effective Date, which is replaced by the Policy.

Primary Residence means the dwelling a person lives in for more than 50% of a given Calendar Year.

Pulmonary Embolism means a sudden blockage in a pulmonary artery or a branch of a pulmonary artery due to a blood clot as confirmed by a pulmonary angiogram, ventilation perfusion scan, computerized tomography scan, magnetic resonance imaging, or other reliable imaging techniques.

Recurrence means a subsequent Diagnosis of a Critical Illness after a benefit for the same Critical Illness has been previously paid.

Renewal Date means the date to which premiums are paid and the date on which the next premium is due to continue this Certificate in force.

Rider means an additional agreement attached to this Certificate for additional coverage.

Skin Cancer means a cancer wherein the tumor cells arise on the surface of the skin. Skin Cancer includes basal cell carcinoma and squamous cell carcinoma.

Skin Cancer does not include:

1. tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia;
2. melanoma skin cancer.

Spouse means an individual who is named as the Spouse on the Enrollment Form, and under state law, is recognized as the spouse of a Primary Insured. Where a state legally recognizes civil unions, a Spouse may include a Primary Insured's partner in that recognized civil union. Where state law provides for registered domestic partnerships, a Spouse may include a Primary Insured's registered domestic partner. We reserve the right to request proof of the legally recognized status of a marriage, civil union, or domestic partnership. Any reference in the Policy to divorce shall also include the legal dissolution of a civil union or domestic partnership.

Stem Cell/Bone Marrow Transplant means a Diagnosis of the need for an autologous or allogeneic transplant of bone marrow, necessitated by compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis must be made by a Medical Practitioner who is a hematologist or oncologist. The need for transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

Stroke means an acute cerebral vascular incident producing permanent, neurological impairment and resulting in measurable objective neurological deficit.

A Stroke with neurologic impairment must be:

1. confirmed by a clinical Diagnosis or neuroimaging study;
2. a result of damage to brain tissue caused by either thrombosis, hemorrhage or embolism;
3. determined by a Medical Practitioner that neurologic impairment resulted from the cerebral vascular event currently being Diagnosed and was not previously present.

Stroke does not include Transient Ischemic Attacks (TIA) or attacks of vertebrobasilar ischemia.

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, hypertension, valvular heart disease, primary heart rhythm abnormality such as Brugada syndrome, long QT syndrome or congenital heart disease.

Total Disability or Totally Disabled means the Primary Insured is unable to perform all of the substantial and material duties of the Primary Insured's regular occupation as required by the Primary Insured's employer (if any). Total Disability must be certified by the Primary Insured's Medical Practitioner. The Primary Insured is deemed Totally Disabled during any period such person is Confined in a Hospital.

Transient Ischemic Attack (TIA) means Diagnosis of a transient episode of neurologic dysfunction caused by focal brain, spinal cord or retinal ischemia, without acute infarction, that is confirmed via documented neurological deficit and neuroimaging studies. Evidence of TIA must show:

1. a new ischemic event with no cerebral tissue damage and reversible impairment as confirmed by a clinical Diagnosis;
2. a clinical Diagnosis that includes documentation of recommended Treatment for Stroke prevention;
3. impairment that is focal and confined to an area of the brain perfused by a specific artery.

Treatment means medical advice, Diagnosis, care or services (including diagnostic measures) received by a Covered Person, or the use of drugs or medicines by a Covered Person.

We, us, our (whether or not capitalized) means Madison National Life Insurance Company, Inc.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

1241 John Q. Hammons Drive, Madison, WI 53717● PO Box 5008, Madison, WI 53705
(800) 356-9601 ● www.madisonlife.com

Critical Illness Insurance Policy

THIS POLICY IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND US.

THIS POLICY IS GOVERNED BY THE LAWS OF THE ISSUE STATE AND, TO THE EXTENT APPLICABLE, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) AND ANY OF ITS AMENDMENTS.

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY. If the Policyholder is not satisfied with the Policy for any reason, the Policyholder may return it to us within 30 days after it is received. Once returned, we will refund the premiums paid, and the Policy will be voided from the Policy Effective Date.

This Policy is signed for us by:

President and Chief Executive Officer

Executive Vice President and Corporate Secretary

THIS IS A CRITICAL ILLNESS POLICY. IT PROVIDES LIMITED BENEFITS. BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS POLICY CAREFULLY.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF A COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON SHOULD REVIEW A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

POLICY INDEX GUIDE

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Madison National Life
a Horace Mann company

POLICY SCHEDULE PAGE

POLICY NUMBER:	013781GR2
POLICYHOLDER:	West Des Moines CSD
POLICY EFFECTIVE DATE:	July 1, 2026
ISSUE STATE:	Iowa
PREMIUM DUE DATE:	First of each month

PREMIUMS

Premium Mode: Monthly

For

Class 1: All full-time employees that are Actively at Work for the Policyholder.

$20,000 Benefit Amount **Age**	**18-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-69**
Primary Insured Only	$4.62	$6.04	$8.43	$11.91	$18.16	$27.48	$41.15	$55.45	$89.54
Primary Insured and Spouse	$7.74	$9.70	$13.06	$18.09	$27.54	$42.59	$65.76	$90.52	$148.12
Primary Insured and Child(ren)	$8.15	$9.57	$11.96	$15.43	$21.69	$31.01	$44.67	$58.97	$93.06
Primary Insured and Family	$12.13	$14.08	$17.44	$22.48	$31.92	$46.97	$70.15	$94.91	$152.50

INCORPORATION PROVISION

The following forms are incorporated into and made a part of this Policy:

1. the group application;
2. all Primary Insured enrollment forms and evidence of insurability forms, if any;
3. the Certificate(s) of coverage; and
4. any amendments, Riders, or endorsements to this Policy or the Certificate(s).

If there is any conflict between the terms and conditions of this Policy and any incorporated form, this Policy shall be controlling. However, in no case will any Covered Person's rights and benefits under this Policy be less than those stated in the Certificate.

PREMIUM PROVISIONS

Payment of Premiums

Unless otherwise agreed to by the Policyholder and Us, the Policyholder must pay premiums to Us at Our Home Office. The first premium is due on the Policy Effective Date. All subsequent premiums are due on the Premium Due Date. The premium for additional, increased, reduced, or terminated insurance may cause a pro-rata adjustment on the next Premium Due Date.

Premium Rates

The premium rates to be charged for the Primary Insured and Dependents, if applicable, are shown on the Policy Schedule Page. The Policyholder will periodically be given the opportunity to modify the group that was originally insured and add new classes of eligible persons.

Premium Changes

After the initial premium rates have been in effect for 24 months from the Policy Effective Date, We may recalculate premium rates. We also have the right to recalculate the initial or any subsequent premium rate when:

1. the terms of this Policy change;
2. the description of an Eligible Class(es) changes;
3. one or more Eligible Class(es) are added to or deleted from this Policy.

For any change in premium rates, We will give the Policyholder 60 days advance written notice. We will not change the rates more than once in any period of 12 consecutive months.

Grace Period

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium. During the Grace Period, this Policy shall continue in force unless the Policyholder gives Us written notice of termination in advance of the date of termination and in accordance with the terms of this Policy. If the entire premium is not paid by the end of the Grace Period, this Policy will terminate.

Reinstatement

If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy. However, if We or Our agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy will be reinstated upon the earlier of the approval of the application by Us, or the 45th day following the date of the conditional receipt unless We have previously notified the Policyholder in writing of Our disapproval of the application.

The reinstated Policy shall cover only loss due to Critical Illness beginning more than 10 days after the date of reinstatement. In all other respects, all parties shall have the same rights as under this Policy immediately before the due date of the defaulted premium, subject to the provisions of any rider which may be attached in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Return of Premium

In the event of termination of this Policy, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Policyholder shall promptly pay, on a pro-rata basis, the unpaid earned premium.

TERMINATION

After this Policy has been in force for 12 months, We may terminate this Policy at any time by giving the Policyholder at least 45 days advance written notice. The Policyholder may also terminate this Policy by giving Us at least 45 days advance written notice. This Policy will automatically terminate if the required premium is not paid by the Policyholder as provided in the Grace Period provision.

We may terminate this Policy upon not less than 45 days advance written notice if the Policyholder fails to comply with a material plan provision relating to the Policyholder's group participation rules, which requires enrollment of at least 10 Primary Insureds or 15% of eligible individuals, whichever is greater.

It is the Policyholder's responsibility to notify each Primary Insured upon termination of the Policy, unless state law requires Us to provide such notification.

GENERAL PROVISIONS

Entire Contract

This Policy, including any endorsements, amendments and Riders, the Policyholder application which is attached to this Policy when issued, Covered Person enrollment forms and the Certificate(s) issued comprise the entire contract between the parties.

Incontestability

The validity of this Policy shall not be contested except for nonpayment of premiums after it has been in force for 2 years from the Policy Effective Date.

Statements

All statements made by the Policyholder or any Covered Person shall be deemed representations and not warranties, and no such statements shall be used in the defense of a claim unless a copy of the instrument containing the statement is or has been furnished to the Covered Person or, in the event of the death or incapacity of the Covered Person, to the individual's beneficiary or personal representative.

Certificates

We will give Certificates to the Policyholder, in electronic or paper form, for delivery to persons covered under this Policy, or We will deliver Certificates directly to persons covered under this Policy if agreed to by Us and the Policyholder. The Certificates will include conditions of eligibility, what benefits are payable and to whom and those provisions of this Policy relative to the procedure to be followed in filing a claim.

Changes to This Policy

We may change the provisions of this Policy upon not less than 45 days advance written notice, unless the Policyholder accepts an amendment during that period. This Policy may also be amended at any time by mutual agreement between the Policyholder and Us without the consent of any Covered Person, but without prejudice to any loss incurred prior to the effective date of the amendment. A change must be approved by one of Our executive officers, and shall not be valid unless and until such change is endorsed in this Policy or attached hereto. No agent can change this Policy or waive any of its provisions. Payment of the applicable premium following any change of this Policy in accordance with this section shall constitute acceptance of that change.

Data To Be Furnished

The Policyholder shall give Us all the information We need that pertains to this insurance. At any reasonable time while this Policy is in force and for one year after that, We may inspect any of the Policyholder's documents, books, or records which may affect the insurance or premiums of this Policy. If the Policyholder gives Us any incorrect information, the relevant facts will be reviewed to establish if insurance is in effect and in what amount. No person shall be deprived of insurance to which such person is otherwise entitled or have insurance to which such person is not entitled, because of any misstatements of fact by the Policyholder or Covered Person. Any required adjustment may be made in coverage, premiums or benefits. However, payment of premium by or on behalf of an ineligible person will not entitle that person to coverage.

Right To Audit

We reserve the right to audit the Policyholder's billing records and premium accounting practices. If We discover an underpayment of premium, the Policyholder will be obligated to remit, in a timely manner, the underpayment amount. In the event of an overpayment of premium, We will return any overpayment amount in a timely manner.

Conformity with State and Federal Laws

Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Adjustments in the Event of Clerical Error

Clerical error, whether by the Policyholder or Us, will not void, alter, extend, increase, decrease, or otherwise affect any coverage provided under the Policy. The terms of the Policy will be adjusted as necessary to correct any clerical errors.

Time Periods

Unless otherwise specifically stated, all time periods begin and end at 12:01 A.M., Standard Time at the place where this Policy is delivered.

MADISON NATIONAL
LIFE INSURANCE COMPANY, INC.

CRITICAL ILLNESS INSURANCE POLICY

THIS IS A CRITICAL ILLNESS POLICY. IT PROVIDES LIMITED BENEFITS. BENEFITS ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. PLEASE READ THIS POLICY CAREFULLY.

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MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

1241 John Q. Hammons Drive, Madison, WI 53717● PO Box 5008, Madison, WI 53705
(800) 356-9601 ● www.madisonlife.com

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

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance:

• $300,000 in death benefits

• $100,000 in net cash surrender and withdrawal values

Health Insurance:

• $500,000 for health benefit plans (see definition below)

• $300,000 in disability income protection insurance benefits

• $300,000 in long-term care insurance benefits

• $100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values

Annuities:

• $250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to health benefit plans.

“Health benefit plan” is defined in the applicable Iowa law and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. 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 under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's *website at www.ialifega.org*, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut, Street, Suite 1300
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings.

The Association is subject to the supervision of the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.