CNO SERVICES, LLC

GROUP INSURANCE PLAN

SUMMARY PLAN DESCRIPTION

(As Amended July 1, 2012)

SUMMARY PLAN DESCRIPTION
FOR
CNO SERVICES, LLC
GROUP INSURANCE PLAN

Introduction

This document is a summary of the CNO Services, LLC Group Insurance Plan (referred to as the "Plan"). The Plan is designed to provide insurance protection for the eligible associates of CNO Services, LLC (the "Company") and related employers who participate in the Plan. The Company and the related employers that adopt the Plan are each referred to as an "Employer." The purpose of this document is to acquaint you with the general provisions of the Plan and to advise you of your rights as a participant under the Plan. This Summary Plan Description is intended to be an easily understood explanation of the more important Plan provisions. However, the Plan itself is a detailed legal document, written in accordance with federal law. Should this summary differ in any way from the provisions of the Plan, the terms of the Plan will govern. All benefits under the Plan are provided pursuant to insurance contracts between the Employers and the insurance companies. The rights and benefits of each insurance policy are set forth in the insurance certificates or booklets you received. Those certificates or booklets and this summary should be kept as part of your records. We urge you to carefully review this summary and the insurance certificates or booklets and to ask any questions about the content or to obtain additional information regarding the Plan from the Plan Administrator. Copies of the Plan and insurance contracts are on file at the Company's principal office and will be made available to any participant or any other person entitled to benefits under the Plan upon request.

This summary reflects the provisions of the Plan effective as of July 1, 2012.

TABLE OF CONTENTS

Page

GENERAL INFORMATION

Name of Plan
CNO Services, LLC Group Insurance Plan

Name, address and employer identification number (EIN) of the Plan sponsor
CNO Services, LLC
11825 N. Pennsylvania Street
Carmel, Indiana 46032
EIN: 35-1965822

Name, address and EIN of the other adopting Employers
Bankers Life and Casualty Company
111 East Wacker Drive
Chicago, Illinois 60601
EIN: 36-0770740

40|86 Advisors
11825 N. Pennsylvania Street
Carmel, Indiana 46032
EIN: 22-2403791

Agent for legal process
Legal process may be served upon CNO Services, LLC or upon the person designated by the Company as its resident agent in the Office of the Secretary of State for the State of Indiana.

Plan Number (PN)
502

Plan Type
The Plan described in this summary plan description is a "welfare benefit plan" providing medical, dental, vision, death, disability, and travel accident benefits to eligible individuals.

Plan Year
The financial records of the Plan are kept on a Plan-year basis. The Plan year begins each January 1 and ends each December 31.

Plan Administrator
CNO Services, LLC

Telephone number of Plan Administrator
(317) 817-6100

Type of administration and source of funding
The Plan is fully-insured. Benefits are provided through the insurance companies listed in this summary. Claims for benefits are sent to the applicable insurance company. The insurance companies (not the Employers) are responsible for paying claims under the Plan. The Plan Administrator and insurance companies share responsibility for administering the Plan. Insurance premiums are paid in part by the Employers and in part through contributions made by associates through the Flexible Benefit Plan maintained by the Company, or through after-tax contributions made by associates.

ELIGIBILITY AND PARTICIPATION

As an associate of an Employer, you will become a participant in the Plan when you become eligible for coverage under an insurance policy in accordance with the terms and conditions specified in the policy. You will be covered under a policy at the time, for the period and under the conditions specified in that policy. A copy of all the insurance certificates or booklets has been provided to you. Please review the eligibility information contained in the insurance certificates or booklets and contact your Employer if you have any questions.

A Note About Spousal and Domestic Partner Coverage: If you make a timely election, the Plan will cover your spouse, but only if you are formally married pursuant to the laws of the state in which you reside. In addition, the Plan provides coverage for your same-sex domestic partner as long as the individual meets the requirements for a domestic partner and proper documentation is provided to the Company. Common-law spouses and opposite-sex domestic partners are not eligible to participate in the Plan, even if the terms of the insurance policy might allow for that coverage.

A Note About Dependent Coverage: A child of a Participant who was previously ineligible for coverage under the Plan due to age may remain covered under any of the policies providing dependent coverage until the child's 26th birthday. Adult children who fall into this eligibility category and are not presently covered under the Plan may only commence participation during the annual enrollment period, and in accordance with the provisions of the applicable policy. It is your responsibility to determine if your child falls into this special eligibility category and seek enrollment in a timely manner. Please refer to the insurance certificates or booklets that have been provided to you and contact your Employer if you have any questions about dependent eligibility under any of the policies that are part of this Plan.

A Note About Spousal and Dependent Coverage: All associates must provide proof of eligibility of their spouse and dependents for whom coverage is being sought under the dental and vision policies. If you fail to provide the required information with respect to any individual by the date on which such information is required, you will not be able to enroll that individual as a covered dependent under the dental or vision policy. If the individual has become covered under the dental or vision policy and does not meet the definition of dependent in the policy, the individual will lose coverage under the policy as provided under the affected policy. If you enroll an ineligible individual in the dental or vision policy it will constitute fraud or an intentional misrepresentation of a material fact and you will be held financially and legally responsible for any benefit paid from the plan with respect to such ineligible individual to the extent provided in the policy. Please be certain to carefully review the definition of spouse and dependent in the applicable policy to be certain you understand which individuals may be enrolled in those policies.

A Note About HIPAA Special Enrollment Rights. If you are an otherwise eligible associate and you decline to participate in the dental and vision policies when first eligible or at open enrollment, you and/or your dependents may have the right to elect such coverage upon occurrence of "special enrollment event" as provided by HIPAA. HIPAA special enrollment events generally occur when you or your dependents lose coverage under another employer's group health plan (unless due to failure to pay premiums), and when you gain a dependent through marriage, birth or adoption. You have 30 days from the occurrence of one of these events to notify the Company and enroll in the arrangement or policy. You and/or your dependents may also have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the Company and enroll in the policies.

CONTRIBUTIONS AND FUNDING

The Employers will provide for all of the Plan's funding through the maintenance of insurance policies. The premiums for the policies will be paid by your Employer, and to the extent determined by the Company, by you. The Company will determine and periodically communicate your share of the cost of the premiums. The Company may change the amount of the premiums you are required to pay at any time.

If you are an otherwise eligible participant and your wages become insufficient to continue payment of contributions and premiums pursuant to your pre-tax salary reduction election under the Company's flexible benefit plan, you are required to pay your contributions and premiums on an after-tax basis for each month that you are a Participant. The Company will notify you of the amount and due date of your payments. **In the event that your required payments are not paid by the due date provided by the Company, your coverage will be terminated. Termination of your coverage will be effective as of the date of your last payment, and to the extent that you may have received benefits under a Plan arrangement or policy during that time, you will be required to repay the Plan for those benefits. In addition, you will not be eligible to enroll in the Plan until the next Plan annual enrollment period as determined by the administrator.**

SUMMARY OF PLAN BENEFITS

The Plan provides eligible associates and their dependents with health, dental, vision, life, accidental death and dismemberment, long-term disability, and travel accident insurance. These benefits are provided under group insurance contracts and more specifically set forth in the insurance certificates or booklets you have received. The following is a list of the insurance or policies provided under the Plan.

SunLife– under a group life and accidental death and dismemberment insurance policy.

CIGNA – under a group long-term disability insurance policy (Prudential Insurance Company through December 31, 2012).

CIGNA DHMO – under a group dental insurance policy.

Delta Dental – under a group dental insurance policy.

Vision Service Plan – under a group vision insurance policy.

Managed Health Network – under a group employee assistance program ("EAP") policy.

CIGNA – under a group travel accident insurance policy.

The address and phone number of each insurance company is listed in the applicable insurance certificate or booklet.

All benefits under the Plan are provided in accordance with the terms and conditions of the insurance policies.

Qualified Medical Child Support Order

With respect to group dental and vision coverage, the Plan will provide benefits as required by any qualified medical child support order ("QMCSO"). The Plan has detailed procedures for determining whether an order qualifies as a QMSCO. You can obtain, without charge, a copy of the Plan's QMSCO procedures from the Plan Administrator.

Benefits for Adopted Children

With respect to group dental and vision coverage, the Plan will provide benefits to dependent children placed with you or your beneficiary for adoption under the same terms and conditions as apply in the case of dependent children who are the natural children of you or your beneficiary.

HIPAA Creditable Coverage Rights

In addition, if you receive dental or vision coverage under the Plan, any exclusionary periods of coverage for preexisting conditions under your group health insurance policy may be reduced or eliminated, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage.

NO ENLARGEMENT OF EMPLOYMENT RIGHTS

Nothing contained in the Plan, insurance policies or this summary is to be construed as a contract of employment between the Employers and you, nor can the Plan be deemed to give you the right to be retained in the employ of the Employers, or limit the right of the Employers to employ or discharge any person or to discipline any associate.

AMENDMENT OR TERMINATION OF THE PLAN

The Company, as the Plan sponsor, has the right to amend the Plan at any time in its sole discretion. While the Company expects and intends to continue the Plan, it also has the right to terminate the Plan at any time in its sole discretion.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA continuation coverage is a continuation of Plan coverage when coverage (including coverage under the dental, vision, or EAP policies) would otherwise end due to a "qualifying event." Specific qualifying events are listed below. Upon the occurrence of a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, associates, spouses of associates, and dependent children of associates may be qualified beneficiaries. Same-sex domestic partners are not qualified beneficiaries under COBRA, and are not eligible for continuation coverage. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage with after-tax dollars.

Who is entitled to elect COBRA Continuation Coverage?

If you are an associate, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an associate, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-associate dies;
- The parent-associate's hours of employment are reduced;
- The parent-associate's employment ends for any reason other than his or her gross misconduct; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Special qualifying event for Retirees

- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed by the Company, and that bankruptcy results in the loss of coverage of any retired associate covered under the Plan, the retired associate will become a qualified beneficiary with respect to the bankruptcy. The retired associate's spouse, surviving spouse and dependent-children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

<u>When is COBRA coverage available</u>?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. You and/ or your dependents will be provided a notice of your right to election COBRA continuation coverage within forty-four days after the Company (as Plan Administrator) is notified of a qualifying event. If, after the Plan Administrator receives your notice of a qualifying event, he or she determines that you and/or your dependents are not eligible for COBRA continuation coverage, the Plan Administrator will provide an explanation containing the reasons you or your dependents are not eligible for coverage. The Plan Administrator will also notify you or your dependents if you are enrolled in COBRA continuation coverage if your COBRA continuation coverage terminates prior to the end of the maximum applicable coverage period.

<u>Sometimes, the Company Must Notify the Plan Administrator</u>:

The Company will notify the Plan Administrator of you or your dependent's qualifying event when the qualifying event is the end of employment or reduction of hours of employment, or death of the associate. You need not notify the Company of any of these three qualifying events.

Sometimes, You Must Notify the Plan Administrator:

For the other qualifying events (divorce or legal separation of the associate and spouse or a dependent-child's losing eligibility for coverage as a dependent-child), you must notify the Plan Administrator. The Plan requires you to provide written notification of the qualifying event to the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the address (including e-mail) provided below. IF YOU DO NOT NOTIFY THE PLAN ADMINISTRATOR OF THE QUALIFYING EVENT WITHIN 60 DAYS AFTER THE QUALIFYING EVENT OCCURS, YOU WILL NOT BE ABLE TO ELECT TO RECEIVE COBRA CONTINUATION COVERAGE.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of you spouse, and you or your spouse may elect COBRA continuation coverage on behalf of your children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, enrollment of the associate in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts up for up to 36 months.

When the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA continuation coverage. You should send such notice of disability to the address provided below.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can obtain additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the address provided below.

Effective June 23, 2014, please send Notices, in writing, to the COBRA Administrator designated below:

MyCNOBenefits
5601 N. MacArthur Blvd.
Irving, TX 75038
844-426-6236

If you have questions about your COBRA continuation coverage, you can write or call the CNO Benefits Service Center at the above address and phone number. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at *www.dol.gov/ebsa*.

Keep Your Plan Informed of Address Changes:

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage under the dental, vision and EAP policies for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

HIPAA COMPLIANCE

The Plan must comply with certain of the requirements under the *Standards for Privacy of Individually Identifiable Health Information* (the "Privacy Regulations") and the *Security Standards for the Protection of Electronic Protected Health Information* (the "Security Regulations"), 45 CFR 160 and 164, as well as the provisions of the *HITECH Act* effective February 17, 2010. The Plan will only receive summary health information, as that term is defined at 45 CFR 164.504(a), for the purpose of obtaining premium bids from health insurers for providing health insurance coverage (including dental, vision and EAP coverage) under the Plan; or (b) modifying, amending or terminating a policy. In addition, the Plan may receive and disclose to the Plan sponsor information on whether the individual is participating in a policy or is enrolled in or has disenrolled form health insurance offered by the Plan. The Plan will also safeguard electronic protected information in accordance with the Security Regulations, including implementing or addressing the administrative, technical and physical safeguards found in the Security Regulations (as is reasonable in light of the limited electronic protected information the Plan receives). You have certain other rights that must be provided to you by the health insurers offering health policies under the Plan. Please contact each insurer directly regarding your HIPAA rights.

CLAIMS PROCEDURES

Each insurance company is responsible for evaluating all benefit claims under the insurance policy it issued under the Plan. The applicable insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and the Patient Protection and Affordable Care Act ("PPACA"), if applicable. The insurance companies have the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

You should review the appropriate insurance certificate or booklet for more information about how to file a claim and for details regarding the insurance company's claims procedures.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and the PPACA, if applicable. If you don't appeal on time, you may lose your right to file suit in a state or federal court, as you may have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

You should review the appropriate insurance certificate or booklet for more information about how to appeal a denied claim and for details regarding the insurance company's claims procedures.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), filed by the Plan, if required, with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if required to be filed, and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report, if a Form 5500 Series is required to be filed.

COBRA and HIPAA Rights

If you are covered under the Plan's or dental, vision or EAP policy, you may be eligible to continue coverage for yourself, spouse or dependents if there is a loss of coverage under that policy as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description, the applicable plan arrangements, and other documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If you receive dental, vision or EAP benefits under the Plan, any exclusionary periods of coverage for preexisting conditions under the medical benefit arrangement may be reduced or eliminated if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental, vision or EAP insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Employee Benefits Security Administration addresses and telephone numbers are available through the EBSA website at www.dol.gov/ebsa.

KD_4293860_3