CNO SERVICES, LLC

SHORT TERM DISABILITY PLAN

SUMMARY PLAN DESCRIPTION

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Introduction

This document is a summary of the CNO Services, LLC Short Term Disability Plan (referred to as the "Plan"). The Plan is designed to provide disability benefits for the eligible employees 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 benefits 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 document. Should this summary differ in any way from the provisions of the Plan, the terms of the Plan will govern. The short-term disability benefits under the Plan are provided through the general assets of the Employers.

We urge you to carefully review this summary, and to ask any questions about the content or to obtain additional information regarding the Plan from MyCNOBenefits. Copies of the Plan are on file with the Plan Administrator.

This summary reflects the terms of the Plan as of January 1, 2014.

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GENERAL INFORMATION

Name of Plan
CNO Services, LLC Short Term Disability Plan

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

Name and address of the other adopting Employers
Bankers Life and Casualty Company
222 Merchandise Mart Plaza
Chicago. IL 60654
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)
509

Plan Type
The Plan described in this summary plan description is a short-term disability plan providing disability 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 short-term disability ("STD") benefits are self-funded. The benefits are provided through the general assets of the Employers. The cost for these benefits is paid by the Employers. The

Company is responsible for the administration of the Plan, and may designate a third-party administrator to handle certain claims administration functions on its behalf.

ELIGIBILITY AND PARTICIPATION

If you are an associate of an Employer, you are eligible to participate in the Plan on the first day of the month after completing one full month of full-time employment with an Employer, provided that you are a full-time associate on that date. If you are not in active service upon your eligibility date, your coverage will be effective upon your return to active full-time service. You are a full-time associate if you are regularly scheduled to work at least 30 hours per week for an Employer. Associates classified as part-time, seasonal, temporary or leased or as an independent contractor or contract employee are not eligible for benefits under the Plan.

Unless you are receiving disability benefits under the Plan, your coverage (and any benefits otherwise payable) under the Plan will end if you terminate employment or otherwise cease to be classified as a full-time associate. In addition, your coverage (and any benefits otherwise payable) will end if you take an unapproved leave of absence from full-time employment. If you are receiving disability benefits under the Plan, your benefits will cease as provided in the Section below entitled "***Commencement and Termination of Benefits***."

CONTRIBUTIONS AND FUNDING

Benefits under the Plan are funded through payments by the Employers from their general assets. There is no insurance policy or designated fund to pay STD benefits and no employee contributions are required.

SUMMARY OF PLAN BENEFITS

The Plan provides eligible employees with short-term disability ("STD") benefits.

Definition of Disability

Under the terms of the Plan, you have a "disability" that will qualify you for benefits if you (1) are unable to work in your regular job due to illness or injury, (2) complete an application for STD benefits and submit the application to the designated claims administrator for approval, (3) are under a physician's care, (4) provide all requested documentation (that the Company deems sufficient) to verify the nature and extent of the disability, and (5) you satisfy the 7-calendar day waiting period. Please note that the Company may require a medical opinion from a physician of its choice confirming that you are unable to work. The Company may also require you to provide additional documentation of your disability during the period of disability.

Amount of Benefit

If you qualify for STD benefits, you will receive 60 percent of the base pay amount you would have received had you not been absent from work for the period described below. The benefit will be paid for a maximum of 90 calendar days. The benefit may end before the end of the 90-day period. See the Section below entitled "***Commencement and Termination of Benefits***."

Coordination with STD Bank and Accrued Personal and Vacation Time

To the extent it is available, you must use time accrued in your STD bank to supplement the 60% STD benefit, up to a maximum of 100% of your pay. You cannot use personal and vacation days to supplement the STD benefit under the Plan.

STD benefit payments will begin on the first work day after the seventh calendar day of continuous disability. Any available accumulated time in your STD bank must be used during the waiting period. If your STD bank is exhausted (due to the required supplementation of the 60% STD benefit described above), you must use any accumulated personal time during the waiting period. You are only permitted to take unpaid leave during the seven day waiting period if you have exhausted all of your STD bank and you have also exhausted your accumulated personal time. You may use your accrued vacation time during the seven day waiting period if you have used all of your STD bank and your accrued personal time.

Commencement and Termination of Benefits

STD benefits are payable while the approved, physician-authorized disability continues but will end upon the earliest of (1) the date your disability ends, (ii) the end of the 90th calendar day of disability, (2) the date you become eligible for Long-Term Disability (LTD) benefits under the Employer's LTD plan, (iv) the date you return to work for an Employer or (v) the date of your death.

If an Employer-paid holiday is observed during the first 5 consecutive work days of a disability leave of absence, you will be paid for the holiday. You will not be eligible for employer-paid holidays after 5 consecutive work days of disability. STD pay is processed through the Employer's regular payroll system and cycle. Any payroll deductions that you have in place at the time you become disabled will continue to be withheld from your STD benefit payments to the extent provided in any other Employer-sponsored benefit plan.

Subsequent Leave Periods

If, after being on approved disability and receiving STD benefits, you return to work for less than two weeks and become disabled again due to the same cause, your disability will be considered "continuous," and the minimum seven-day elimination period will not apply before STD benefits begin again. In this case, the maximum benefit period of 90 calendar days will apply to the cumulative disability leave. If you return to work for more than two weeks or become disabled again due to another cause, you first leave will be disregarded for purposes of determining your STD benefits for the second disability leave.

Exclusions

No STD benefits will be paid for disabilities caused by an act of war, whether declared or undeclared, or any disabilities caused or contributed to by, or resulting from the your (1) intentionally self-inflicted injuries; (2) active participation in a riot; (3) commission of a crime for which you are convicted by a court of competent jurisdiction under state or federal law; (4) occupational sickness or injury. For purposes of the Plan, an "occupational sickness or injury" is

defined as an injury arising out of, or in the course of, any work for wage or profit for any employer, or any sickness covered by any workers compensation or occupational disease law.

Family and Medical Leave Act

If you qualify for leave under the Family Medical Leave Act due to your own qualifying medical condition, you will be eligible for STD benefits only for the medically necessary portion of your leave. The "FMLA" leave and STD benefit periods run concurrently. If the leave is due to the qualifying condition of a family member, no STD benefits will be paid.

Coordination of Benefits

The gross amount of any STD benefit will be reduced by the amount, if any, you receive or are entitled to receive under any state funded disability program.

CLAIMS AND REVIEW PROCEDURES

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Plan Administrator. You must complete your claim according to directions provided by the Plan Administrator. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Claim Administrator appointed by the Plan Administrator.

The Plan Administrator is the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Plan Administrator has the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on participants to the full extent permitted by law. You must file a written claim to the Committee or seek a review of the Committee's benefit determination. The Committee will provide you or your beneficiary a full and fair review upon your request.

If a claim for benefits by you is denied, either in whole or in part, the Plan Administrator will let the claimant know in writing within 45 days. If special circumstances require an extension of time for processing a claim, the Plan Administrator will let the claimant know of the extension, which cannot exceed 30 additional days. If, due to matters beyond the Plan Administrator's control, a decision cannot be made, the period may be extended for an additional 30 days, provided that the Plan Administrator:

- notifies the claimant of the circumstances requiring the extension;
- specifically explains the standards on which the claimant's right to a benefit is based;

- explains the unresolved issues that prevent the Plan Administrator's decision on the claim; and

- requests any additional information needed to resolve those issues.

The claimant will have at least 45 days to provide the specific information, and if the information is not provided by the claimant, the period for making a benefit determination will continue until the information is provided.

If the claimant does not hear anything from the Plan Administrator within 45 the claimant may treat the claim as if it had been denied. A notice of a denial of claim:

- will refer to a specific reason or reasons for the denial of the claim;

- will have specific references to the Plan provisions upon which the denial is based;

- will describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary;

- will have an explanation of the Plan's review procedure; and

- will identify any medical or vocational experts whose advice was obtained.

The claimant will have 180 days after the date of the denial to ask for a review and a hearing by written request filed with the Plan Administrator. During this time, the claimant may review pertinent documents and may submit issues and comments in writing. The Plan Administrator will have another 45 days in which to consider the claimant's request for review. If special circumstances require an extension of time for processing, the Plan Administrator may have an additional 45 days to answer the claimant. The claimant will receive a written notice if the extra days are needed. If the extension is needed because the claimant has not provided requested information necessary to decide the claim, the period for review will continue until the information is provided by the claimant. The claimant may submit in writing any document, issues and comments he or she may wish. The decision of the Plan Administrator will tell the claimant the specific reasons for its actions, and refer the claimant to the specific Plan provisions upon which its decision is based.

MISCELLANEOUS

Plan Administration

As "plan administrator" and "named fiduciary," the Company is responsible for the administration and management of the Plan, including giving directions concerning all payments from the Plan.

FMLA and USERRA

This Plan will operate in compliance with the Family and Medical Leave Act of 1993 (FMLA) and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Please contact the Plan Administrator should you have questions regarding these rules.

Duty to Furnish Information and Documents

You must furnish to the Plan Administrator such information as the Plan Administrator considers necessary to administer the Plan. All parties to, or claiming any interest under the Plan must perform any and all acts and execute any and all documents necessary for carrying out the Plan. You should also ensure the Plan Administrator has your current address at all times. Failure to do so may result in a loss of benefits or a delay in payment.

No Enlargement of Employment Rights

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

Electronic Delivery

The Company may deliver this Summary Plan Description and other important Plan information to you using electronic means. This Summary Plan Description contains important information concerning the rights and benefits of your Plan. If you receive this Summary Plan Description (or any other Plan information) through electronic means you are entitled to request a paper copy of this document, free of charge, from the Plan Administrator. The electronic version of this document contains substantially the same style, format and content as the paper version.

AMENDMENT OR TERMINATION OF THE PLAN

The Company, 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. Your coverage under the Plan will end at (and no benefits will be paid after) that time.

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 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 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.

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 Employer, 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.

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