FAQs | 2012 Benefits Frequently Asked Questions

FAQs | New in 2012

1. What's changing in CNO's benefits for 2012?

Wellness – CNO is partnering with OurHealth, an independent health management company, to support CNO's For Your Health! wellness program. (OurHealth replaces RedBrick Health as CNO's wellness provider.) OurHealth provides a total wellness solution combining onsite services in CNO's three main locations with telephonic and online resources available to all associates and family members participating in CNO's medical plan. Read more FAQs about OurHealth and the onsite clinics in the OurHealth FAQ section below.

Medical - CNO's medical plan options are not changing in 2012. CNO offers two high-deductible plan options that can be paired with your own health savings account. The medical plan's deductibles, co-insurance and out-of-pocket maximum are unchanged. CNO is enhancing the prescription drug benefit by offering generic preventive maintenance medications at no cost when they are obtained from CIGNA Home Delivery or through one of CNO's onsite clinics.

Flexible Spending Accounts (FSA) – CNO is simplifying our benefit strategy for FSA by making the following changes:

- *Health care FSA is restricted in 2012.* Participation in the health care FSA is limited to associates who are not enrolled in a medical plan option under the CNO Care Options Plan or who are not eligible to contribute to an individual Health Savings Account (HSA.)
- *Limited health care FSA will no longer be offered.* If you enroll in a CNO medical option under the CNO Care Options Plan and are eligible for an HSA, you should consider budgeting eligible out-of-pocket expenses and making contributions to your HSA to meet those expenses.
- *The FSA Grace Period has been eliminated.* This means you only have until December 31, 2012 to incur an eligible expense for reimbursement from your dependent care or health care FSA.

Other Benefits – There have been no changes to the dental, vision, life, or long-term disability insurance benefits, or to the Employee Assistance Program.

2. **What is the new Generic Preventive Maintenance (Generic PM) prescription drugbenefit and how can I take advantage of it?**

   The Generic PM prescription drug benefit includes those generic preventive maintenance medications used for the prevention of conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency. To receive a Generic PM medication at no cost you need to obtain it from either CIGNA Home Delivery or from one of CNO's onsite clinics. You can set up CIGNA Home Delivery for a 90-day supply of medications by calling CIGNA at (800)285-4812.

3. **What if I obtain a Generic PM at a retail pharmacy?**

   If you obtain a Generic PM medication at a retail pharmacy, you will be subject to the Tier 1 deductible and co-insurance.

4. **Are all generic medications free?**

   No, only prescriptions that are for generic preventive maintenance medications obtained through home delivery or at the clinic will be provided at no cost to participants. You can identify Generic PM medications on CIGNA's drug list (mycigna.com) as any generic (Tier1) drug with a "PM" after the drug name. All other generic medications included in Tier 1 are subject to the medical plan deductible and co-insurance.

5. **What if I my maintenance medication isn't a generic?**

   If you're using a Tier 2 or Tier 3 maintenance medication (i.e. a brand name drug), you will be subject to the medical plan deductible and co-insurance. You may want to talk with your physician to determine if a generic form of your medication is available and would work for you.

FAQs | OurHealth and OurClinics@CNO

6. **Who is OurHealth?**

   OurHealth is an independent, clinically-driven and dedicated provider of integrated on-site health management programs for employer groups. OurHealth is not affiliated with any established hospital, health system, pharmacy, or health insurer. OurHealth, along with its partnership with OurHealth Physician Group, provides staffing, support, and management of on-site health and wellness clinics, as well as chronic condition management, and wellness programs focused on enhancing the health and productivity of individuals, and the value of health care services received.

7. **How will OurClinics @ CNO, support the For Your Health! program?**

   All eligible Iindividuals (as defined in FAQ #9) can obtain their health screening (including height and weight measurement, cholesterol and hemoglobin A1c testing) on-site at the clinic. The results of the screening will be communicated privately and securely to those individuals. OurHealth will also offer, through its online portal, access to the HealthMedia® Succeed™ HRA (health risk assessment) and other online wellness programs. OurHealth offers tools to help individuals make progress toward their goals and incentive targets, including online, in-person and telephonic health coaching and lifestyle management, as well as access to on-site physician services.

8. **What services will OurHealth offer in the clinic?**

   In addition to the support of the For Your Health! wellness program noted above, OurClinics@CNO offers urgent/convenient care services, general primary care services, laboratory testing, generic pharmacy services, health coaching and lifestyle management.

9. Who will be eligible for clinic services?

CNO has elected to offer the services to all associates, as well as spouses and dependents age 13 and older enrolled in the CNO Care Options Plan. Branch associates (and their spouses and dependents enrolled in the CNO Care Options Plan) can participate in the For Your Health! wellness program, and can access on-site clinic services when visiting corporate locations, in addition to full access to the online portal services and telephonic coaching.

10. What wellness, coaching, or disease management services does OurHealth offer?

Eligible associates, their participating spouse, and their participating dependents over the age of 18 can visit ourhealth.org and sign in to OurPortal℠ to view health information, access their health records, and complete their health risk assessment. Based upon one's unique situation, online coaching tools are readily available and tailored to each individual's needs. OurHealth offers programs focused on weight management, healthy eating, fitness & exercise, smoking cessation, stress management, chronic pain, back pain, diabetes, depression, insomnia, and management of chronic conditions such as high blood pressure and high cholesterol. In addition to the online programs, in-person health coaching will be available at each of OurClinics@CNO locations, and telephonic coaching will be available to all employees, spouses and dependents over the age of 18 enrolled in the CNO Care Options Plan.

11. What medical services are offered by OurClinics@CNO?

The clinic provides services very comparable to a community physician office or stand-alone ambulatory practice, including urgent care needs as well as ongoing primary care and the maintenance of chronic medical problems. Typical examples include infections, injuries, rashes, headaches, abdominal pain, heart and lung disease, diabetes, and annual preventive care exams. No different than outpatient primary care practices, OurClinics@CNO will not provide emergency care.

12. How does one schedule a visit in the clinic?

Visits can be scheduled conveniently online, by telephone, or in-person at one of OurClinic@CNO locations. Email message reminders will be sent to members immediately before the provider is ready to avoid waiting before your appointment.

13. Generally, how long are visits in the clinic?

Patients will have a dedicated 20 minutes with the provider for urgent care needs and 40 minutes for new appointments or annual physicals. The OurHealth model allows for more direct time with a provider to optimize the quality of care provided and great patient experience.

14. Can I have lab work done in the clinic?

Yes, most routine lab services are available on-site. Results of most tests are available electronically for patients within days after completion. Patients can have blood work done that is ordered by an OurHealth provider, but also can bring test orders from other physicians (i.e. cardiologist, etc.), and have the results sent directly to the ordering physician.

15. Can I obtain prescriptions in the clinic?

Yes, pharmacy services will be available at the clinic. OurClinics@CNO will carry approximately 80 types of generic medication – both acute and maintenance medications are available with a prescription from an OurHealth provider. Examples of medications available include acute medications such as antibiotics and allergy medications, and maintenance medications for conditions such as blood pressure, cholesterol, or depression/anxiety. Controlled substances such as narcotics are not carried in the clinic. Prescriptions from physicians outside of OurHealth, such as a specialist or personal physician may be able to be filled in the clinic, depending on the unique situation of a given patient, and after at least an initial consultation with an OurHealth physician to ensure avoidance of any safety or quality issues. A list of available medications will be available on OurHealth's online portal.

16. Can I obtain a same-day appointment in the clinic?

Yes, the clinic reserves time each day for urgent same-day appointments. In most circumstances you can schedule a visit to see a provider that day, but it cannot be guaranteed.

17. Is my health information shared with CNO?

No individually identifiable health information will be shared with CNO. OurHealth is committed to protecting the privacy and security of its patients and is compliant with all State and Federal laws regarding the privacy of individually identifiable health information. OurHealth will provide de-identified aggregate reports to CNO to demonstrate the impact of Our Total Health Management Solution℠. These reports will never contain associate names or other information that could be used to identify an associate or an associate's family members.

18. Can the clinic share information with my personal physician?

Yes, OurHealth is committed to an integrated and patient-centric approach to health care. With the patient's consent, OurHealth will share information from clinic visits and coaching sessions with an associate's community physician(s).

19. What network does OurHealth refer to for specialist care?

OurHealth is an independent health organization and is not owned by, or affiliated with, a single health system. This enables OurHealth providers to refer patients to the most appropriate hospital system or specialist depending on the unique needs and preferences of each patient. OurHealth works as an advocate for patients and by providing information, resources, and guidance enables patients to make more value-conscious decisions. OurHealth staff will also work with patients to educate them on the differences of in-network versus out-of-network providers as part of the referral process.

20. Are vaccines/immunizations (including travel shots) available in the clinic?

Subject to supplies and availability many common vaccines are available. Individuals can check with clinic staff to confirm if a specific vaccine or shot is offered in the clinic.

21. Does the clinic have radiology services on-site?

At this time, OurHealth is not offering on-site radiology services to its members, but is pleased to refer patients to convenient, quality, and cost-effective locations to receive needed imaging services.

22. What is the out of pocket cost for visits in the clinic?

All preventive care services and generic preventive maintenance drugs dispensed in the clinic are provided at no cost to participants. Associates and their eligible family members who visit the clinic for services outside of preventive care must pay out-of-pocket for those services. Fortunately, because the clinic is a dedicated provider of medical care services to CNO associates and their eligible family members, the clinic operates at lower fixed cost than competing urgent and primary care providers. For that reason, it is able to offer affordable non-preventive care services at a lower out-of-pocket cost, in much the same way that CIGNA's in-network providers offer services at a lower cost under the medical plan. The fee schedule for non-preventive care services provided by the clinic are:

- Office visit - $25
- Lab visit - $5
- Prescription - $4

23. Are women's health services available in the clinic?

OurHealth will offer women's health services including annual exams and PAP screens, and will work with the patient to coordinate receiving a periodic mammogram through a referral to an outside provider.

24. Will the clinic provide emergency care?

The clinic is able to meet the majority of patients urgent care needs but is not equipped to manage true emergency care (including, but not limited to, fractures, severe bleeding, respiratory distress, chest pain, trauma, etc.) and all emergency care will be referred to the nearest and most appropriate hospital emergency department similar to any traditional primary care office. It is always recommended that in emergency situations at the workplace, 911 be called immediately.

25. What are the typical hours of the clinic?

While the hours have not yet been finalized, the clinics will be open 40 hours a week during daytime hours for nurse visits. Physician and/or nurse-practitioner hours will be more limited during the week based upon the clinic location's size and needed capacity. Details on the available hours of the clinics will be communicated before the opening of each clinic.

26. Who does OurHealth use to provide clinical services in the clinic?

OurHealth has a partnership with OurHealth Physician Group, an independent, physician-managed organization of doctors, nurse practitioners, and other ancillary staff that support OurClinicSM locations. To provide employers flexibility, OurHealth can also offer other staffing solutions to meet employers' needs & preferences, which may include partnering with an established physician group in your community.

27. What credentials and training do OurHealth providers have?

OurHealth Physician Group is an established, independent group of physicians, nurse practitioners, and ancillary staff that work in OurClinicSM locations. Only well-qualified providers who pass a thorough recruitment and credentialing process including due diligence and a background check are allowed to join OurHealth Physician Group. All providers that serve an OurClinicSM location are actively licensed providers and are board eligible/certified in family practice, internal medicine, or general practice.

28. Does OurHealth have an electronic medical record?

Yes. OurHealth providers in all clinic locations have access to a robust, secure, Web-based electronic medical record to optimize the safety, quality, and efficiency of patient care. The system used by OurHealth, OfficeEMRTM, is certified by the Certification Commission for Health Information Technology nationally, and has the ability to exchange information with other providers in the community and across the State that participate with health information exchanges to enable care to be coordinated across care settings.

29. Why is CNO hiring a firm to manage an on-site clinic versus doing this in-house?

The complexies of managing an on-site clinic along with a total health management program are not core businesses of CNO, and there is value in hiring a firm with expertise in this area dedicated to managing these types of clinics and health management programs. By outsourcing the management of the health care services, CNO can offer eligible participants an additional level of comfort knowing any personal health information is managed, secured, and protected by a third party.

30. How does an on-site clinic impact our current health benefits/insurance?

OurHealth's services are an optional benefit offered in addition to the CNO Care Options Plan. Use of the clinic, and/or participation in the For Your Health! program, will not change the availability of, or access to, health care services available through the CNO Care Options Plan. Eligible participants in the CNO Care Options Plan can still obtain covered services including (but not limited to) pharmacy, diagnostic testing, hospital, primary and specialty care physician services no different than they do today. It is hoped that the convenience, quality, cost-savings, and patient-focused experience provided by OurClinics @ CNO will be viewed as a tremendous benefit to associates of CNO and eligible spouses/dependents.

31. Will I be required to use the on-site clinic or can I still see my personal primary care physician?

OurClinics@CNO are provided as an optional benefit for eligible associates and their elibible family members, and are not intended, in any way, to limit or impact your relationship with your personal physician. The hope is that enhanced access and availability of preventive care and screening services will augment and help promote better overall health. The clinic is committed to share information with your personal physician (or other providers such as a specialist physician) upon your consent and consistent with all privacy and confidentiality laws governing medical records. Support of the For Your Health! Wellness program and convenient access to lab testing and generic drug dispensing are also offered to supplement your health care needs.

FAQs | Medical/Prescriptions

32. Will there be changes to the covered medical services in 2012?

No, there are no changes to covered medical services for 2012. Additionally, there is no difference in covered medical services between Medical Option 1 and Medical Option 2.

33. What are the Medical Options 1 and 2, and how do they work?

In both medical options, you must first meet the annual deductible, and then you and the health plan share expenses through coinsurance, up to the designated out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the plan pays 100% of eligible expenses for the remainder of the plan year. Preventive care services are paid 100% by the plan if you use in-network providers.

34. What is CIGNA's Open Access Plus Network, and how does it work?

CIGNA's Open Access Plus Network is a large group of physicians and facilities that provides CIGNA members with services at discounted rates. Both CNO Medical Options 1 and 2 are supported by CIGNA's Open Access Plus Network. Associates receive a higher level of benefits and lower out-of-pocket expenses when care is received from an in-network provider.

35. What is the CIGNA Care Network, and how does it work?

The program is designed to help associates select the best health care providers for various medical specialties. CIGNA Care Network (CCN) is a designation given to CIGNA HealthCare participating doctors who meet certain criteria based on quality and efficiency. There are 21 specialties to which the CCN applies. You can find a full list of these specialties in the 2012 Benefits Guide, which can be found on Benefits InfoNet.

- If you receive covered services from a CCN-designated specialist, you'll receive the highest level of in-network benefit, which is 80% coinsurance for both Medical Options.
- If you receive covered services in one of the 21 specialties from a CIGNA Open Access Plus participating doctor who isn't a CCN-designated specialist, you'll receive the lower level of in-network benefit, which is 70% coinsurance for both Medical Options.
- If you receive covered services from a specialist who isn't a CIGNA participating doctor, you'll receive benefits at the out-of-network coverage level, which is 50% coinsurance for both Medical Options.

36. How do prescriptions work with CNO's 2012 medical options?

As described in FAQ #2, for 2012, CNO has introduced Generic Preventive Maintenance (Generic PM) medications at no cost when obtained through CIGNA Home Delivery or at one of OurClinics@CNO. For Tier1 through Tier 3 medications, you pay 100% of the cost until your deductible is met. Once your deductible is met, coinsurance applies, as well as per-prescription out-of-pocket maximums, which is indicated on page 7 of the 2012 Benefits Guide. Prescription drugs aren't covered outside the CIGNA pharmacy network. If you have an HSA, you may choose to pay for your out-of-pocket prescription costs with your available HSA funds.

37. How does the mail-order provision work under Medical Options 1 and 2?

If you obtain a Generic PM medication through CIGNA Home Delivery, it is covered 100% by the medical plan. However, for Tier 1 through Tier 3 medications, you pay the full discounted cost of drugs until the annual deductible has been met. Once your deductible is met, co-insurance applies, as well as per-prescription out-of-pocket maximums, which is indicated in the 2012 Benefits Guide. The advantage of using the mail order service is that the discounts for these drugs are generally greater than with the CIGNA in-network pharmacies, and the drugs are delivered to your home.

FAQs | For Your Health! Wellness

38. How can I earn CNO-provided contributions to my HSA?

You'll have multiple opportunities to participate in CNO wellness activities and earn company contributions into your HSA throughout 2012. The total potential company contributions you may earn are as follows, by coverage tier:

- Single: $1,000
- Associate + spouse: $1,500
- Associate + child(ren): $1,500
- Family: $2,000

Click here for a menu of tasks that can be completed to earn company-provided HSA funds.

39. If I my HSA isn't activated before I earn my first wellness incentive contribution, what will happen to my earned incentive funds?

CNO cannot pay wellness incentive contributions until you have opened your HSA. You can earn incentives before you open your HSA, but those incentives will not be paid to you until you open your HSA. Once your account is open and activated, incentive dollars will be deposited within 5-7 business days. As long as your account is opened by December 9, 2012 (the 2012 cutoff date for 2012 wellness incentive funding), you'll receive all of your earned incentive contributions by the end of the year. If your HSA isn't opened by the December 9, 2012, any 2012 wellness incentives earned will be forfeited.

40. When will CNO wellness incentives be deposited into my HSA?

CNO wellness incentives are deposited on a monthly basis. If you earn an incentive by the 15th of the month, it will be deposited into your individual HSA by the 28th of the month. For example, incentives earned from February 16th through March 15th, will be funded into accounts by March 28th.

41. Are there any wellness incentives that I can earn in 2011 for funding in 2012?

Yes. You can take your 2012 Health Assessment on the OurHealth portal in December 2011 for early funding into your HSA in January 2012. Otherwise, all other 2012 wellness incentives must be earned in 2012. This includes annual physicals and biometrics. In 2012, you can receive your annual physical and biometrics at OurClinics@CNO (available to those in a clinic location) or you can schedule a 2012 annual physical with your personal physician and send your annual physical form with biometrics OurHealth in order to earn your 2012 incentive.

42. If I'm enrolled in a CNO medical option, but I'm not eligible to contribute to an HSA, can I still earn wellness incentives?

Yes. If you aren't eligible to contribute to an HSA, you'll need to select the "I am not eligible" option on the HSA Eligibility page in the Benefits Enrollment portal and you will need to enroll in a health care FSA to receive CNO wellness incentives. To do this, you will be required to complete an affidavit certifying the reason that you are not eligible for an HSA and then you will be allowed to enroll in a health care FSA. By doing both steps you will be able to earn your CNO wellness incentives in 2012.

Please note that you must personally contribute a minimum of $10 per month to open your health care FSA. Your combined health care FSA contribution (the amount you contribute plus any CNO contributions for wellness incentives) can't exceed the $5,000 annual contribution limit established under the CNO Services, LLC Flexible Benefit Plan. Also, please remember that, unlike the HSA, the health care FSA is part of the company-sponsored cafeteria plan and is subject to the IRS's "use it or lose it" rule. Accumulated funds must be used to pay for qualified medical, dental or vision expenses that are incurred by you during the applicable plan year (between January 1, 2012, and December 31, 2012). You'll have until March 31, 2013, to submit all health care FSA claims incurred during this time frame for reimbursement. All unused funds will be forfeited at the expiration of the claims submission period.

FAQs | Health Savings Account (HSA)

43. What is an HSA?

An HSA is an individual account you can use to pay for qualified health expenses for yourself and your tax dependents. It belongs to you. If you leave the company, you take the funds with you. You can make contributions to an HSA only while you're covered by a high-deductible health plan (HDHP) and you don't have other first-dollar health coverage (see FAQ #44). Contributions you make to your HSA are tax-free. This reduces your taxable income and potentially your tax liability. When you withdraw funds to pay for qualified health expenses, the funds remain tax-free. However, if you use your HSA funds for nonqualified expenses, the amounts are taxable and you'll be required to pay an additional 20% tax penalty on the withdrawn amount.

43. Is the full amount of my elected contributions to the HSA for the year available at the beginning of the year for me to use?

No. With the HSA, your account funds are available only after contributions have been made to your account either through elective pre-tax payroll deductions, CNO contributions for wellness incentives earned or any other personal contributions you make directly to your HSA.

44. What qualifications must I meet to be eligible to contribute to an HSA?

To contribute to an HSA, you must meet the following requirements:

- You must be enrolled in a high-deductible health plan (HDHP) that meets the IRS requirements (such as one of CNO's Medical Options 1 and 2).
- You can't be covered by another health plan that isn't an HDHP (i.e., you can't be a dependent on anyone else's health plan unless that plan is also a qualifying HDHP, with the exception of plans that provide only preventive care, vision or dental coverage on a first-dollar basis).
- You can't be enrolled in Medicare or Medicaid.
- You can't be claimed as a dependent on another person's tax return.
- Your health claims can't be eligible for reimbursement under any "general purpose" health care Flexible Spending Account (FSA) (including your spouse's FSA).
- You can't have a positive balance in your 2011 general purpose health care FSA on December 31, 2011
- You can't be enrolled in TRICARE coverage.
- You can't have received VA medical coverage within three months from the time of your HSA enrollment, unless covered services were only for dental, vision or preventive care coverage.
- You can't be enrolled in any "Mini-Med" or supplemental health insurance policies if significant medical benefits are provided under the policy, as in providing general benefits for specified medical services such as organ transplant services, ER, hospitalization, outpatient treatment or ambulance services. Note: Specified disease policies (such as cancer policies) and hospital indemnity policies that are limited to a fixed amount per day will not disqualify you from HSA contribution eligibility. Coverage under Bankers Life and Washington National supplemental products offered to associates don't disqualify you from HSA coverage.

45. If I I'm not eligible to contribute to an HSA, can I still enroll in a medical plan option?

Yes. If you're not eligible to contribute to an HSA, you may still enroll in one of CNO's medical options to use the comprehensive medical coverage provided through the CNO Care Options Plan. Additionally, if you're ineligible to contribute to an HSA, you are eligible to open a health care FSA to set aside pre-tax money for your health care expenses as you use the medical plan.

46. Who can contribute to my HSA?

You, CNO or anyone else you designate may contribute to the HSA. However, the maximum contribution is limited annually based on IRS rules and regulations.

47. What's the maximum contribution allowed into my HSA for 2012?

The IRS limits the contribution amount in 2012 to $3,100 for single coverage or $6,250 for any of the family tiers. This limit applies to the combined total of all contributions from you, the company or anyone else who contributes to your account. In addition, if your spouse has an HSA, your combined contribution cannot exceed these IRS annual limits (See FAQ # 52).

48. Can I make changes to my HSA contributions throughout the year?

Yes. Making changes to your contributions does not constitute a change to your actual benefit plan, so there are no restrictions to how often you can change your HSA contribution throughout the year. To make changes to your HSA contribution, logon to HRconnect and select the Benefits Enrollment tab. Click "Change Benefits", and choose "HSA Election" as your reason for your change request. Please note that changes to your contributions may take up to two pay cycles before becoming effective.

49. Will CNO contribute to my HSA in 2012?

Yes. CNO will make company contributions to your HSA for wellness tasks completed throughout the year. You and your spouse (if applicable) can complete wellness tasks to earn contributions into your HSA.

50. If I am eligible for an HSA midyear, can I still contribute the full annual contribution?

Yes. If you become an eligible participant in CNO's medical plan midyear and choose to open an HSA, you may contribute the full annual HSA maximum applicable to your tier of coverage. However, to be eligible for the full-year contribution, midyear HSA participants must remain enrolled in a qualifying high deductible health plan (HDHP) for the entire calendar year following enrollment. Failure to maintain qualifying HDHP coverage for that period will result in income tax and a 20% penalty on all "excess contributions." Excess contributions are any HSA contributions you make for months in which you weren't enrolled in a qualifying HDHP on the first day of the month.

51. If I change medical coverage tiers midyear (e.g., move from family coverage to single coverage), how will that affect my contribution maximums for the year?

If you go up in tier (e.g., from single coverage to family coverage) at any point during the year you'll be allowed to contribute the maximum amount for the higher tier. If you go down in tier (e.g., from family coverage to single coverage), your maximum contribution will be the greater of the annual maximum for your new tier of coverage or a prorated amount calculated based on your new tier of coverage and the month when the change took place.

52. If my spouse and I are both eligible to contribute to HSAs, what is the maximum that the IRS will allow us to contribute collectively to HSAs in 2012?

If you and your spouse are both enrolled in a high-deductible health plan (HDHP) and are both eligible to contribute to an HSA, you may both do so, up to the IRS family maximum. In 2012, the family maximum contribution limit is $6,250; therefore, your and your spouse's combined HSA contributions (including any company-provided contributions) may not exceed $6,250 in 2012. This limitation does not apply to same-sex domestic partners. If you and your same-sex domestic partner are each enrolled in a separate HDHP, you each may contribute the maximum contribution for 2012, based on the tier of coverage in which you are both enrolled ($3,100 for single coverage or $6,250 for any family tier).

53. What expenses are qualified for reimbursement from my HSA?

You're eligible to receive tax-free reimbursement for qualified medical, dental and vision expenses incurred by you and your qualified tax dependents, as long as those expenses are not paid or reimbursed by medical, dental or vision coverage. A list of these qualified expenses is available on the IRS website, www.irs.gov. HSA distributions used for any purpose other than qualified medical expenses are taxable plus a 20% tax penalty is applied.

54. Do I have to use my HSA funds for all of my out-of-pocket medical expenses?

No. You control your HSA funds and decide whether to spend them for your current medical expenses or to spend other out-of-pocket funds and save your HSA for qualified medical expenses incurred in the future.

55. What happens to my HSA if I leave the company?

All funds contributed to your HSA (both by CNO and by you) are yours to keep. You can keep your HSA with JPMorgan Chase or transfer it to another qualifying HSA provider at any time. If you withdraw your funds from the JPMorgan HSA, you must redeposit them into another HSA within 60 days to avoid income tax and the additional 20% tax penalty. (Note: You must continue to meet HSA qualifications to continue making contributions to your HSA. If you're no longer enrolled in a qualified HDHP, you may no longer contribute money to your HSA. However, you may continue to use any funds already contributed to your HSA for qualified medical expenses incurred any time after the date your HSA was established.)

56. Who is JPMorgan Chase, and what role does it play in my HSA?

CIGNA has partnered with JPMorgan Chase to provide HSAs to participants who enroll in either of the medical options under the CNO Care Options Plan. Note: Any HSA contributions that you're electing to make through pre-tax payroll deductions will not be deducted from your paycheck until your account has been activated by JPMorgan Chase. Additionally, CNO contributions for wellness incentives earned by you or your spouse can't be made until your account is activated.

57. How do I set up my HSA with JPMorgan Chase?

If you elect a CNO medical option during annual enrollment and you don't already have a JPMorgan Chase HSA, you must select the "I agree to the terms and conditions" button on the HSA Eligibility page within the Benefits Enrollment portal. Once your account is set up, you'll receive a welcome kit in the mail confirming the activation of your account. This letter will include your Personal Identification Number (PIN) for accessing your HSA website and your HSA debit card and card instructions. If you elect to make pre-tax contributions to your HSA, they won't be deducted from your paycheck until your enrollment is completed and your account is activated.

58. How can I roll over HSA funds from another banking institution to JPMorgan Chase?

You can roll over HSA funds into your JPMorgan Chase account by completing a JPMorgan Chase HSA rollover form. You'll receive this form in your HSA enrollment kit.

59. How do I make contributions to my HSA?

You can make pre-tax contributions through payroll deduction directly to your JPMorgan Chase HSA, after-tax contributions on your own, or you can do both. During annual enrollment, you can elect pre-tax payroll deductions to your JPMorgan Chase HSA. If you establish your HSA with another qualified financial institution, you're responsible for making after-tax contributions to your HSA. If you establish your HSA with a banking institution other than JPMorgan Chase, you won't be eligible to receive any CNO wellness incentives as CNO will only be making contributions to a JPMorgan Chase HSA. However, once funds are deposited to your JPMorgan Chase HSA, those funds belong to you and you can move them to another HSA provider of your choice.

60. How do I use my JPMorgan Chase HSA?

Money in your HSA can be used tax-free for qualified medical expenses, including doctor's office visits, hospitalization and prescription drugs. Always show your CIGNA member ID card when receiving care to receive CIGNA's discount before paying any medical expenses from your HSA. You can pay for qualified medical expenses using your HSA debit card. You can also elect to have your CIGNA claims auto-forwarded to the HSA for payment by accessing your mycigna.com account and selecting this preference. Please note that for debit card transactions or ATM withdrawals, you must keep all receipts and documentation of the qualified medical expense that was paid/reimbursed. The IRS will require substantiation of all qualified medical expenses in the event of an audit. You should also retain all statements from CIGNA and JPMorgan Chase reflecting any automatic payments made through CIGNA's claims forwarding process. Under IRS rules, you are responsible for substantiating that all payments made from your HSA were for qualified medical expenses.

61. What happens if my HSA doesn't have sufficient funds to pay my health care claim?

To have expenses reimbursed from your HSA, you must have sufficient funds in your HSA. If you don't have sufficient funds in your account, your transaction will be rejected.

62. How can I find out more about JPMorgan Chase's HSA investment choices?

You can find out more about JPMorgan Chase's investment choices on mycigna.com. If you aren't enrolled in CNO's medical plan, you can log in to www.mycignaplans.com to view information about investment choices. Username: CNO2012, Password: cigna.

63. Will I have to pay any fees for my JPMorgan Chase HSA?

There are no HSA setup fees, transaction fees, change fees or administrative fees. However, there are certain transaction fees based upon your account activity. Go to Benefits InfoNet to see a list of applicable JPMorgan Chase HSA fees.

64. How do I track the balance in my account or access account information?

You can access your account information 24 hours a day, seven days a week by logging in to www.mycigna.com. On this website, you can view account balances and information, change investment options, process transactions, download forms and link to a list of covered expenses. You can also call CIGNA's customer service at (800) 244-6224.

65. When I withdraw funds from my HSA, what information do I need to keep?

Save all receipts and records of withdrawals for tax reporting to the IRS. If you use your funds for expenses that are not qualifiwed medical expenses, you must report those withdrawals when you file your federal income tax return. You're responsible for maintaining all records associated with your HSA.

66. Can individuals age 65 or older withdraw HSA funds for any reason without penalty?

Once you reach age 65 or older, regardless of whether or not you're enrolled in Medicare, you won't be subject to a 20% tax penalty if you withdraw funds from your HSA for reasons other than to reimburse qualified medical expenses. However, you'll be subject to income tax on those funds if the distribution isn't used for qualified medical expenses.

67. What income tax forms do I need to file when I have an HSA?

You'll need to file IRS Form 8889, along with the standard Form 1040, to report contributions to and distributions from your HSA. You'll receive a 1099 form from JPMorgan Chase (or any HSA provider you choose) indicating your HSA contributions and withdrawals.

68. What are catch-up contributions?

Generally, when you reach age 55 and until you're enrolled in Medicare, you're eligible to make up to $1,000 in additional contributions to your HSA. Assuming you're in an HDHP for the full year that you turn age 55, you're eligible for the full amount of the catch-up contribution. Consult your tax advisor for more information related to your eligibility to make catch-up contributions. To make catch-up contributions at age 55 or older, you'll need to complete an HSA Catch Up Contribution form located on Benefits InfoNet.

FAQs | Flexible Spending Accounts/FSAs

69. What happens if I don't use all of my FSA as of December 31, 2012?

The health care and dependent care FSAs are subject to the IRS "use it or lose it" rule, which means that if you do not use all the funds during the plan year, the unused portion is forfeited. For 2012, CNO has eliminated the grace period previously associated with its FSA programs. This means you must incur qualifying health or dependent care expenses by December 31, 2012. In addition, claims must be submitted to WageWorks no later than March 31, 2013 in order for those claims to be eligible for reimbursement.

70. If I choose to have a health care FSA for medical or a dependent care FSA for child care expenses and I incur a very large eligible expense early in the year, how will reimbursements be processed when the account hasn't yet accumulated enough balance?

The entire amount of your health care FSA annual pledge will be available at the beginning of the plan year (January 1). Contributions to this account are deducted from your wages and applied to your account uniformly during the course of the year in an amount equal to your annual pledge amount. On the other hand, your dependent care FSA annual pledge amount will not be available to you until the contributions are deducted from your wages and applied to your account.

71. If I terminate employment before the end of the year, what happens if my FSA balance doesn't cover the expense that was already paid?

The contributions to your health care and/or dependent care FSA will stop once you terminate employment with CNO. If you withdrew more funds from your health care FSA than you contributed to the account prior to your termination date, you won't be required to pay back those funds. However, any remaining balance in your health care or dependent care FSA will be forfeited unless you incurred sufficient eligible expenses to exhaust your balance prior to your termination and you submit those claims for reimbursement in a timely manner. You may continue your contributions to the health care FSA on an after-tax basis if you elect to do so under your COBRA rights. COBRA continuation coverage is not available for the dependent care FSA.

72. Are teeth-whitening products eligible for FSA reimbursement?

Teeth-whitening products aren't eligible for reimbursement from a health care FSA. For a full list of reimbursable expenses, please go to www.wageworks.com.

FAQs | Dental

73. What happens if the CIGNA Dental HMO (DHMO) dentist I selected isn't accepting new patients when I need to have dental work done?

The dentist networks for the CIGNA DHMO are much smaller than the medical HMO networks. Therefore, when you enroll in this plan, if you aren't already an established patient of the dentist when making your election, you need to be sure that the DHMO dentist you selected will have you listed as an active patient when the time comes that you need dental services. You can't change dental plans in the middle of a plan year because the dentist you selected during enrollment is no longer taking new patients or drops out of the CIGNA DHMO network. Instead, you will have to choose another dentist in the CIGNA DHMO network who is taking new patients. (A suggestion to avoid this potential issue is to make an appointment for a teeth cleaning as soon after your eligibility date as possible. Then, if you need other services later in the year, you'll already be an established patient.)

74. How does the DeltaPreferred PPO work?

With the DeltaPreferred PPO, you have the freedom to select any licensed dentist you wish. Your benefits will be greater if you see a DeltaPreferred PPO dentist. A deductible must be satisfied for basic restorative or major restorative care. The plan pays a percentage of covered charges after the deductible.

75. What is the DeltaPreferred Passive PPO?

With the DeltaPreferred Passive PPO, the plan pays a percentage of covered charges up to the usual and customary rates (UCR.) You may still see any licensed dentist you wish without penalty, and all covered benefits are exactly the same as the Delta Preferred PPO, including deductibles and coinsurance. The difference is that if you receive treatment from a dentist who participates in the DeltaPreferred network, your fees will be discounted, thereby reducing your out-of-pocket expenses. The dentist also won't bill you for any amounts that exceed the UCR limits.

FAQs | Vision

76. How are vision exams, glasses and contact lenses covered on the plan?

You and your dependents receive one eye exam per year if you're enrolled in one of the medical plan options administered by CIGNA. If you also enroll in VSP you will have coverage for an additional eye exam, prescription eyeglasses and contact lenses. VSP is an employee-paid plan. All questions concerning providers and services can be directed to VSP's customer service number at (800) 877-7195 or by visiting their website at www.vsp.com.

77. Who processes claims for prescriptions written by a VSP eye doctor?

If the medicine were necessary to treat a medical problem in your eye, the medication would be covered under the medical plan prescription drug benefit. If, at the time of purchase, you're told that the medicine isn't covered, it may be that your particular medication is on the prescription drug exclusion list or is actually an over-the-counter item. Review the CNO Care Options Plan Summary Plan Description for more information.

FAQs | Life Insurance/Lont-Term Disability (LTD) Insurance

78. What is the maximum life insurance I can select without Evidence of Insurability (EOI)?

Associates with existing supplemental term life/AD&D policies on themselves have a maximum of $500,000 when combining company paid and supplemental life insurance. Each year, enrolled associates are able to increase their supplemental amount by one option level (e.g., from $50,000 to $100,000 or $300,000 to $400,000) up to the $500,000 Guaranteed Issue amount, without having to provide EOI. However, if the combined total between the company-paid life amount (one times your salary) and the supplemental face amount when you increase by one level is greater than $500,000, you'll have to provide EOI.

79. How do I update my current beneficiaries for my life insurance?

If you're not sure of who you have currently listed as your life insurance beneficiaries, please submit updated information to us to ensure that our records reflect your desired beneficiary information. To update your beneficiary information, log in to HRconnect. Once logged in, access the "Benefits Enrollment" tab, and then click on "Manage Beneficiary Information" to make any desired changes. This electronic submission will replace any paper beneficiary forms that are currently on file for you.

80. What is the amount of my LTD benefit?

If you become disabled, you'll receive a benefit in the amount of either 40% or 60% of your monthly covered earnings, depending on your election. Company-paid LTD coverage is 40% of your monthly covered earnings, subject to a monthly maximum benefit of $7,500 if you become disabled. (The annual salary amount to reach the maximum benefit of $7,500 is $225,000 or more at the 40% level.) Buy-up LTD coverage is 60% of your monthly covered earnings, subject to a monthly maximum of $15,000 if you elect this coverage and become disabled. (The annual salary amount to reach the maximum benefit of $15,000 is $300,000 at the 60% level.)

81. How can I determine if I have a pre-existing condition that makes me ineligible for LTD coverage?

You have a pre-existing condition if both points below are true:

- You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the three months just prior to your effective date of coverage, or in the three months just prior to the date that an increase in benefits would otherwise be available.
- Your disability begins within 12 months of the date that your coverage under the LTD policy becomes effective.

FAQs | Dependent Eligibility

82. Under what circumstances is my child, spouse or same-sex domestic partner eligible to participate in CNO's benefit plans?

If you elect medical, dental, vision or supplemental term life/AD&D insurance coverage for yourself, you may also elect coverage for your lawful spouse (as defined under applicable state law) or same-sex domestic partner (as defined in the CNO Care Options Plan). Your lawful spouse doesn't include a "common-law spouse." A common-law spouse isn't an eligible dependent under any CNO benefit plan. To comply with the Patient Protection and Affordable Care Act, the CNO Care Options Plan extends eligibility for any child based on the child's relationship with you – regardless of student status, marital status or access to other health coverage – until the child's 26th birthday. "Children" include:

- Your biological children or stepchildren, and children of your domestic partner if the child resides with you.
- The children of your qualifying same-sex domestic partner if the children reside with you
- Your legally adopted children and children formally placed with you for adoption.
- Your foster children and children for whom you have been appointed legal guardian pursuant to a court order.

A disabled child is eligible to remain covered after the child attains age 26 under certain circumstances – refer to your summary plan description for more information.

Your child's eligibility to participate in CNO benefits other than the CNO Care Options Plan is determined based on the terms of the applicable benefit arrangement or policy.

FAQs | Changing Benefits/Qualifying Events

83. When can I change my benefit elections?

You may only change your plan elections during Annual Enrollment, unless you experience a qualifying event. Examples of qualifying events include the birth or adoption of a child, a marital status change, the death of a spouse or child, a change in child eligibility, or a change of employment for you or your spouse where benefits are affected. If you experience a qualifying event, you may make benefit changes consistent with your change in status as long as you complete the qualifying event process within 30 days from the date of the event.

84. How do I add or drop dependents from my insurance?

You can add or drop a dependent (including a spouse, same-sex domestic partner and eligible child) only during Annual Enrollment unless you experience a qualifying event (as defined in the applicable plans). If you experience a qualifying event, you must access **HR*connect*** to complete your benefit change request **within 30 days** from the date of the qualifying event. If you don't submit your request within this time frame, your request will be denied and your next opportunity to enroll will be during the 2013 Annual Enrollment.

FAQs | Continuation of Benefit Coverage (COBRA)

85. When does my health care coverage end if I leave the company, and how can I continue coverage?

Your current coverage will continue until the last day of the month in which the termination date falls. If elected, COBRA coverage is effective the first day of the month after the coverage termination date, and yoiu will not experience a break in coverage. A COBRA packet is mailed via certified mail to your current home address on file. It will explain the procedures you should follow and the deadlines you must adhere to in the event you or a covered dependent wishes to continue coverage pursuant to COBRA. Information related to the cost of continuation coverage and due dates for your premium payments will also be included in these materials.

86. What is COBRA? How does it work?

COBRA refers to continuation of your medical, dental and vision coverage under the benefit arrangement or policy in which you are currently enrolled as an associate of CNO. It's also available to spouses and children if they're enrolled in medical, dental or vision coverage and experience a COBRA "qualifying event." If you and/or any of your family members experience a COBRA qualifying event (such as termination of employment, divorce or a child's loss of eligibility under the plans' terms), you'll have 60 days from the date you receive a COBRA election notice to enroll in COBRA. Premiums are paid at a higher rate than associate premiums, and if elected, monthly billing coupons will be mailed to you informing you of the applicable premium and due date.

FAQs | Miscellaneous

87. Which benefits are taken from my check on a pre-tax basis, and which are taken on an after-tax basis?

Benefit deductions taken pre-tax include medical, dental, vision HSA contributions and FSA elections. Those taken after-tax include supplemental life, 20% buy-up LTD option, Conseco supplemental products and any fitness-related deductions.

88. What is an EOB?

An EOB is the Explanation of Benefits issued by the applicable administrator or insurer after a benefit claim is received. This explanation may include the date of service, the medical code for the service rendered, the amount the medical provider is charging for such service, the amount of charges that will be considered for payment, the plan's financial responsibility and any out-of-pocket expenses. You can obtain copies of your EOBs for claims submitted to the CNO Care Options Plan by registering or logging in to www.mycigna.com.

89. What is a pre-existing condition, and who may be subject to a pre-existing condition exclusion or limitation?

A pre-existing condition is an injury or illness for which you've received treatment or medication, incurred expenses or received a diagnosis by a physician during a specific period before: (1) beginning an eligibility waiting period; or (2) becoming covered under the applicable benefit planfor these benefits. Please review the applicable summary plan description for information related to any pre-existing condition limitation or exclusion.

Pre-existing condition exclusions applicable to medical coverage are subject to additional regulation under federal law. For purposes of your medical coverage under the CNO Care Options Plan, please note:

- If you or your covered dependent(s) are under age 19, pre-existing condition clauses will not apply to you.
- If you or your covered dependent(s) are age 19+ and have been continuously covered under another qualified medical plan option prior to eligibility for one of the plans offered by CNO, pre-existing limitations will generally not apply to you (this is commonly known as "creditable coverage").
- If you or your covered dependent(s) are age 19+ and have had a break in coverage of 63 or more days just prior to eligibility for coverage under the CNO Care Options Plan, there may be a period of time during which charges for the pre-existing condition are excluded from coverage.
- The medical plan's pre-existing condition exclusion does not apply to the following:
  - Pregnancy.
  - Genetic information with no related treatments.
  - Any eligible plan participant under the age of 19.