OURCLINICS@CNO
WELLNESS PROGRAM

SUMMARY PLAN DESCRIPTION

(Effective January 1, 2012)

SUMMARY PLAN DESCRIPTION
FOR
OURCLINICS@CNO
WELLNESS PROGRAM

Introduction

This document is a summary of the OurClinics@CNO Wellness Program (referred to as the "Plan"). The Plan is designed to provide self-funded on-site clinic, wellness and health management services to 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 the self-funded benefit arrangements established by the Employers. The rights and benefits of each arrangement are set forth in the For Your Health! program summaries (including booklets, brochures and other published materials) that you have received. Those summaries and this summary should be kept as part of your records. We urge you to carefully review this summary and the program summaries and to ask any questions about the content or to obtain additional information regarding the Plan from the Plan Administrator. Copies of the Plan contracts and arrangements 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 January 1, 2012.

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GENERAL INFORMATION

Name of Plan
OurClinics@CNO Wellness Program

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 60601-4508
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)
504

Plan Type
The Plan described in this summary plan description is a "welfare benefit plan" providing on-site clinic services, wellness and health management 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 self-funded. Benefits are provided through the general assets of the Employers. The Plan Administrator and third-party providers share responsibility for administering the Plan. Except for coverage provided to COBRA participants, the cost of all benefits provided under the Plan are paid by the Employers.

ELIGIBILITY AND PARTICIPATION

Eligibility Criteria. You are eligible to participate in the Plan if you are employed in an eligible classification as established by the Employers. Eligible classifications include both full-time regular employees and part-time regular employees. Additionally, a full-time regular Employee of the Company's foreign-based affiliate, CNO India, will become an Eligible Employee, and automatically become a Participant in the Plan, during any period of temporary work assignment in a domestic location of the Employers. Your coverage will begin automatically upon your first day of employment in an eligible classification.

Your spouse, qualifying same-sex domestic partner, and/or child will automatically become covered dependents under the Plan upon commencement of your participation, but only if your spouse, qualifying same-sex domestic partner, and/or child are eligible for and enrolled in the CNOCare Options Plan. In addition, your child must have attained age 13 in order to be eligible to participate in this Plan.

If you are classified as a temporary, leased or seasonal employee, or as an independent contractor or contract employee, you are not eligible to participate in this Plan.

Please contact the Plan Administrator identified in the General Information section of this summary if you have questions about your or your dependents' eligibility.

CONTRIBUTIONS AND FUNDING

The Employers will provide for all of the Plan's funding through contributions from their general assets. Except as required by the Plan's continuation coverage provisions, you are not required to contribute to the cost of coverage, although the Employers reserve the right to require contributions from participants at any time in order to continue providing benefits under the arrangements. Should such a determination be made, the Company is required to communicate any cost of coverage to you.

SUMMARY OF PLAN BENEFITS

The Plan provides eligible employees and their dependents with on-site clinic, wellness and health management benefits. These benefits are provided under self-funded benefit arrangements established in conjunction with a third-party medical service provider as set forth in the summaries you have received. The following is a list of the Plan's third-party service providers:

OurHealth LLC – the "OurClinics@CNO" on-site clinic arrangement.

OurHealth LLC– the "For Your Health!" wellness and health management arrangement.

The contact information for OurHealth is provided in the program summaries you have received. All benefits under the Plan are provided in accordance with the terms and conditions of the arrangements, as set forth in the contracts between OurHealth and the Company, the Plan document, and the program summaries.

NO ENLARGEMENT OF EMPLOYMENT RIGHTS

Nothing contained in the Plan, the benefit arrangements, 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 employee.

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 under Plan 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, employees, spouses of employees, 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 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 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 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.

When is COBRA coverage available?

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 elect COBRA continuation coverage within forty-four days after the Company/Plan Administrator receives notice 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.

Sometimes, the Company Must Notify the Plan Administrator:

The Company will notify the Plan Administrator of you or your dependent's qualifying event when the qualifying event is the end of the associate's 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 your 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.

Please send Notices, in writing, to the COBRA Administrator designated below:

ADP Benefit Services
P.O. Box 2968
Alpharetta, GA 30023-2968
1-800-522-6621

If you have questions about your COBRA continuation coverage, you can write or call the ADP 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 Plan 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 this Plan.

HIPAA COMPLIANCE

The Plan is exempt from direct compliance with the requirements under the HIPAA *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. However, pursuant to its agreement with OurHealth LLC, neither the Plan nor the Employers will receive your personal health information. In fact, the Plan will only receive summary health information, and only to the extent necessary to administer the Plan.

As a provider of medical services, OurHealth LLC is required to comply with HIPAA's Privacy Regulations and Security Regulations, including providing you with a Notice of Privacy Practices. Please contact OurHealth directly if you have questions about your HIPAA rights under the arrangements.

CLAIMS PROCEDURES

The Plan's third-party service providers are responsible for determining the covered services available to you under the Plan, and will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If necessary, the third-party service provider has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

If your request for benefits or services under the Plan is denied, you will receive written notification of the denial, as well as the reasons for the denial. Upon receipt of such denial, you may appeal to the Administrator for a review of the denied claim. You have 180 days from receipt of written notification of denial to appeal the determination. The Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. 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).

If you have questions about the Plan's claims procedures or appeal rights, please contact the Plan Administrator identified in the General Information section of this summary.

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, you may be eligible to continue coverage for yourself, spouse or dependents if there is a loss of coverage 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.

This Plan provides only "excepted benefits" as that term is defined in federal law. For that reason, HIPAA's preexisting condition limitations and certificate of creditable coverage requirements do not apply to this Plan.

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_3961775_2.DOCX