CNO SERVICES, LLC

FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

(As amended effective January 1 and July 1, 2012)

Introduction

CNO Services, LLC (the "Company") maintains the CNO Services, LLC Flexible Benefit Plan (the "Plan") to enable its eligible employees and the eligible employees of the other participating employers to choose between current cash compensation and benefits under certain welfare plans and programs the Company sponsors. You may make contributions to the Plan to pay for the cost of those benefit programs on a "pre-tax" basis through this Plan, and under certain circumstances, on an "after-tax" basis through this Plan.

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 the federal law. Should this summary differ in any way from the provisions of the Plan, the terms of the Plan will govern. If you have any questions concerning the Plan, you should contact the HR Service Center or obtain a copy of the Plan. If you have any questions about a benefit claim or Plan forms, you should contact WageWorks.

The Plan was originally effective as of January 1, 1988; however, it has been restated in its entirety effective as of January 1, 2012 and amended effective as of July 1, 2012. This summary reflects the provisions of the amended Plan in effect as of July 1, 2012.

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*** * Important Information * ***

Name and Address of Plan Sponsor:

CNO Services, LLC
11825 North Pennsylvania Street
Carmel, Indiana 46032

Employer Identification Number (EIN): 35-146832

Plan Name: CNO Services, LLC Flexible Benefit Plan

Plan Number: 503

Plan Type: Welfare benefit "cafeteria" plan providing medical and dependent care benefits to eligible individuals and individual health savings account contributions

Plan Year: The Plan year commences on January 1 of each year and ends on December 31 of that year, and records are kept on that basis.

Type of Administration:

The Company is the Plan administrator. The Plan administrator administers the Plan according to the terms of the Plan. The Company has retained a third-party administrator to process claims and perform certain ministerial duties.

Third Party Administrator:

WageWorksCorporation
1100 Park Place, 4th floor
San Mateo, CA 94403
877-924-3967

Funding: The Plan is funded by direct benefit payments from the general assets of the Employers. Neither the third party administrator nor any insurance company is responsible for the financing or ultimate payment of any claim under the Plan.

Service of Legal Process:

Legal process may be served upon the Plan administrator 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.

Name, Address and EIN of the Other Adopting Employers:

Bankers Life and Casualty Company
600 W Chicago Ave
Chicago, Illinois 60610
EIN: 36-0770740

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

I. PARTICIPATION

A. Plan Entry.

You are eligible to become a participant in the Plan for the purpose of paying your share of the premiums for coverage under the welfare benefit plans sponsored by the Employers (listed in Part II below) on the day you become covered under those welfare benefit plans. (Normally, this will occur on the first day of a calendar month.) You will be eligible to become a participant in this Plan for the purpose of electing coverage under the Plan's flexible spending accounts (or "FSAs"), both the Health Care FSA and the Dependent Care FSA, if you are regularly scheduled to work at least 30 hours per week, excluding any overtime work. Your participation for purposes of the Plan's Health Care FSA and Dependent Care FSA Programs will automatically begin on the first day of the month after you have completed one full month of service as a "full-time, regular" associate of a participating employer regardless of whether you contribute to either FSA. You are eligible to make pre-tax contributions to your individual health savings account ("HSA") after you begin participating in the Employers' high deductible health plan and establish an account at a qualifying financial institution.

B. Termination of Participation.

Your participation in the Plan will stop (i) on the last day of the month in which you become a "part-time" or temporary associate, so that you are no longer employed as a 'regular' associate scheduled to work at least 30 hours per week, (ii) on the last day of the month in which your employment with all the participating employers terminates, (iii) on the date the Plan is terminated or (iv) on the date you fail to make any required contributions.

See Section IV below for the rules relating to your participation if you terminate employment and are then reemployed or if you have been a part-time associate and then become a full-time associate.

II. PLAN BENEFITS

A. Flexible Benefits Account.

As a participant, a Flexible Benefits Account will be established on your behalf under the Plan. You will then be able to use the credits made to your Flexible Benefits Account during each Plan year (see paragraph B below for an explanation of how the credits are determined) to "purchase" various optional benefits offered through the Plan. Some of these benefits are paid on a "pre-tax" basis. This means the amount you have withheld from your pay is not reported as taxable income to you (for either income tax or social security tax purposes). Under certain circumstances, your benefits will be paid on an "after-tax" basis. This means the amount you have withheld from your pay is reported as taxable income to you.

Pre-tax benefits include:

a) Medical coverage

b) Dental insurance coverage

c) Vision insurance coverage

d) Individual HSA contributions

After-tax benefits include:

e) Supplemental life insurance coverage

f) Spousal/dependent life insurance coverage

g) Supplemental long-term disability insurance coverage

h) Cancer insurance coverage

i) Heart insurance coverage

j) Accident Secure insurance coverage

k) Worksite Universal Life coverage

l) Hospital Secure coverage

m) Bankers Long-Term Care coverage

n) Carmel Total Fitness membership

o) Monon Center membership

Note: Only coverage offered through the CNO Care Options Plan (which is considered "medical coverage" for this purpose), the CNO Services, LLC Group Insurance Plan or a designated CNO affiliate may be purchased through this Plan.

You are also able to accumulate dollars to pay for dependent care expenses you incur during a Plan year and you may be able to accumulate dollars to pay for certain medical care expenses you incur but which may not be covered by the benefit plans. This is done through credits to the Health FSA and the Dependent Care FSA maintained under this Plan. (See Sections V and VI below for more information on these FSAs.) All credits to either of these FSAs are made on a pre-tax basis.

B. Account Credits.

1. Sources of Account Credits.

Account credits are the contributions you make to the Plan through payroll withholdings. You may elect to make contributions to the Plan for one or more of the optional benefits described in paragraph A above when you enter the Plan, during the Plan's annual enrollment period, or upon a qualified change of status.

The amount you elect to contribute will be subtracted from your first two paychecks of each month. The contributions will be accumulated in your Flexible Benefit Account and then used to pay for your elected benefits. Any unused accumulated amounts in your account at the end of the year will be forfeited.

2. Credit Amounts.

You may elect to have a fixed dollar amount of your compensation withheld from your paycheck and converted into credits to your Flexible Benefits Account (your "Pay Credits"). Your Pay Credit election will equal the cost of the benefit options you select.

3. Pay Credit Elections.

To convert your pay into Pay Credits for any Plan year, you must file a written election during that Plan year's annual enrollment period. The annual enrollment period generally runs during the month of October that precedes the beginning of the Plan year. Withholding will begin with the first pay period beginning on or after the following January 1 the start of the Plan year. The maximum amount of Pay Credits you can elect for a Plan year is the cost of the optional benefits you select.

Your Pay Credit election, other than your election for the Heath Care FSA and Dependent Care FSA, will continue in effect until changed during a subsequent enrollment period or immediately after a change in status. If you do not make an election during the annual enrollment period, your benefits will be waived and any Health Care FSA or Dependent Care FSA Program elections will be reduced to zero. Additionally, your employer has the right to reduce your election if it must do so to comply with the nondiscrimination requirements of the Internal Revenue Code.

4. Change in Status.

It is very important that you estimate your expenses accurately, since the election you make generally cannot be changed until the next year. As mentioned previously, you may only change your election if (i) you have a change in status, (ii) your election change is consistent with the change in status event and (iii) you notify the Company of the event within 30 days of the event happening. The "change in status" rules are contained in a complex set of IRS regulations, but generally include events such as:

- Marriage
- Divorce
- Death of a spouse or child
- A change in the number of dependents
- A spouse's termination or commencement of employment
- Change from part-time to full-time or from full-time to part-time status by you or your spouse.

Note 1: For dependent care accounts, you may be able to change your election amount one time during the year if there's a change in your dependent care provider. Suitable documentation will need to be provided before any change is approved.

Note 2: "Financial hardship" is not a change in status recognized by the IRS for flex plans. Because of the complex nature of these rules, you should contact the Company or a WageWorks representative if you have any questions concerning a change in status.

Note 3: You may have the right to modify your elections upon the occurrence of "special enrollment event" as provided by HIPAA. HIPAA special enrollment events generally occur when you or your dependents lose coverage under another employer's group health plan (unless due to failure to pay premiums), and when you gain a dependent through marriage, birth or adoption. You have 30 days from the occurrence of one of these events to notify the Company and make an election change that is consistent with the event. You and/or your dependents may also have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the Company and make an election change that is consistent with the event.

C. Account Allocations.

1. General Rule.

The amounts credited to your Flexible Benefits Account during a Plan year will be used:

- To pay for any required premiums for one or more of the pre-tax optional benefits you select.
- To pay for any required premiums or fees for one or more of the after-tax optional benefits you select.
- To be credited to your Health Care FSA sub-account to be used to reimburse you for qualifying expenses you incur under the Health Care FSA Program (see Section V) up to a maximum of $5,000.
- To be credited to your Dependent Care FSA sub-account to be used to reimburse you for qualifying expenses you incur under the Dependent Care FSA Program (see Section VI) up to a maximum of $5,000 (or such lesser amount as explained in Section VI)
- To be deposited into your individual HSA, to be used by you to pay or reimburse qualifying medical expenses.

2. After-Tax Benefits.

If you elect coverage for a domestic partner, no pre-tax amounts can be used to pay premiums for that coverage. As an after-tax benefit, the premiums must be paid on an after-tax basis. The amount not allocated each pay period will be transferred to your account and will be treated as taxable income paid to

you in the month the transfer occurs. Under certain circumstances, your premiums and contributions to the Plan will be deducted from commission income on an after-tax basis, pursuant to an authorization signed by you.

3. Automatic Increases / Decreases in Premium Payments.

If you have allocated Pay Credits to pay for an optional benefit and the cost of that benefit goes up during the Plan year (other than (i) an increase in cost under the Health FSA or (ii) an increase in cost under the Dependent Care FSA charged by your relative), your employer will automatically have more of your pay converted to Pay Credits to the extent needed to pay for the increased cost.

Example: If your Pay Credits for a Plan year are $200 and you elect to allocate $150 towards the cost of your medical coverage (with the remaining $50 allocated to your Health Care FSA sub-account) and the insurance cost goes up to $200, your employer will automatically increase the amount of your pay converted to Pay Credits to $250 so that your entire premium amount would be paid under the Plan. In addition, if the cost of an optional benefit decreases, your employer will automatically make a corresponding reduction in your Pay Credits.

D. Forfeiture of Credits.

Any amount in your Flexible Benefits Account that is not used to pay premiums or reimburse you for qualifying medical or dependent care assistance expenses incurred during the Plan year will be forfeited. In addition, after a check has been issued to pay a claim under a Flexible Benefit Account, if the check has not been cashed after eighteen months, the Plan's obligation to pay the benefit underlying the uncashed check is extinguished and the funds will be forfeited. Credits allocated to one optional benefit may not be used to pay for the cost of another optional benefit nor will you be able to change your elections during the Plan year absent a change in status. For example, amounts in your Health Care FSA subaccount that are not used during a Plan year may not be used to pay for dependent care assistance expenses or to pay for insurance premiums. Therefore, care must be taken in determining your credit allocation for any Plan year to make sure you do not forfeit any dollars. You should be mindful to consider the following when deciding upon your contribution to your Flexible Benefits Account: your eligible and predictable health care expenses; your eligible dependent care expenses; your income and tax bracket; and your reduction in paycheck since part of your salary is set aside for expenses.

E. Account Funding.

Credits to your Flexible Benefits Account are for accounting purposes only. Except for contributions to your individual HSA, no funds will be segregated or transferred outside of the Employers, except to pay for insurance premiums or to reimburse you for qualifying expenses under the Health Care FSA or

Dependent Care FSA Programs.

III. BENEFIT PAYMENTS

A. Insurance Premiums.

Flexible Benefits Account credits you allocate to pay for the cost of your insurance or CNO Care Options Plan "premiums" will automatically be used by your employer to pay that premium.

B. FSA Reimbursements.

Flexible Benefits Account credits you allocate to the Health Care FSA or Dependent Care FSA Programs will be used to reimburse you for qualifying expenses under those programs.

1. Completing and Submitting Manual Reimbursement Claims.

You should take care to completely and accurately complete reimbursement claim forms. If you request funds from the wrong account, reimbursements will not be made until a corrected claim form is received for the expense. Reimbursement claim forms must be filled out completely, including itemized expenses. Use the appropriate claim form for each account (Health Care or Dependent Care). Make sure to indicate the amount requested, sign and date the form. You should also attach any and all receipts and supporting documents to the voucher. You should make copies of all receipts and supporting documents to keep for your own record.

Claims will be processed for expenses determined by WageWorks to be reimbursable under one of the programs and supported by sufficient documentation. Reimbursement checks will be mailed as soon as practical. When mailing the claim forms and receipts, please allow adequate mailing time. Claim forms may also be faxed to WageWorks with supporting documentation. All reimbursements for qualifying expenses, must be submitted on written claim forms to WageWorks no later than March 31 after the end of the Plan year in which the expenses were incurred to be reimbursed from that year's accumulated accounts. You must also submit any supporting documentation that WageWorks deems necessary. (See the list in Section VIII for common types of expenses and required documents.) Reimbursements will be limited to the amount in your FSA or deemed to be in your FSA at the time your claim is submitted.

It is important to note that effective January 1, 2011, over-the-counter medications (such as pain relievers, cold, and allergy medications) are NOT eligible for reimbursement from your health care FSA or your individual HSA unless these medications or drugs are prescribed by a doctor. However, this restriction does not apply to Insulin, or to medical supplies or devices. This change was made as part of the health care reform legislation enacted in 2010.

As a result of another change brought about under health care reform enacted in 2010, you are permitted to submit a claim for reimbursement to your Health Care FSA for otherwise-eligible qualified medical, dental, and vision expenses that you pay for your child until the year in which your child attains age 27, regardless of your child's residency, student status, marital status, or financial dependency upon you. However, in order to reimburse yourself from your individual HSA for qualified medical expenses of your adult children, your adult child must be your "tax dependent " (e.g. unmarried, full-time student under age 23, financially dependent upon you for support) as in previous years.

2. The WageWorks Health Care Card

The Health Care Card works like a MasterCard at approved locations. You can present the Health Care Card at participating IIAS certified merchants, as well as physician, dental and vision service locations. The card will electronically deduct approved expenses from your Health Care FSA account. When your FSA election is depleted, the transaction will be declined at the cash register.

3. HSA

If you are eligible to make contributions to an individual HSA, you will not be eligible to participate in the Health Care FSA. If you are not eligible to make contributions to an individual HSA and you elect at open enrollment to make contributions to a health FSA, the funds that you elect to contribute to your Health Care FSA will be available to reimburse you for all qualifying medical expenses not otherwise reimbursed through the Care Options Plan or other insurance coverage.

IV. TERMINATION OF EMPLOYMENT AND REEMPLOYMENT

A. Termination of Employment.

Upon your termination of employment with the employers, your participation in the Plan will stop. No further Pay Credits will be made unless you make a COBRA election under the Health Care FSA Program.

If you have a credit balance in either your Health Care FSA or your Dependent Care FSA subaccounts, you may continue to submit claims for reimbursement for the duration of the claims submission period as if you were still a participant until your credit balance is used up. However, you may only be reimbursed for claims incurred prior to your termination. Claims incurred after your termination will only be reimbursed under the Health Care FSA Program if you are eligible for and elect COBRA continuation coverage.

Your individual HSA remains your account upon termination of employment.

B. Reemployment.

If your employment terminates and you are rehired by a participating employer more than 30 days following your date of termination, you will be treated as a new employee and you will again become a Plan participant as described in Section I. However, if you are rehired in the same calendar month that your employment terminated, you will be treated, for purposes of the Plan, as though you had not terminated employment and any elections in place at the time of your termination will automatically be reinstated. If you are rehired after the month in which your employment terminated but within 30 days of your date of termination, you will again become a Plan participant the first day of the month following the month in which you were rehired. However, any elections in place at the time of your termination will automatically be reinstated when you resume participation in the Plan.

If you cease to be a Plan participant because you were not regularly scheduled to work 30 or more hours per week and you later increase your scheduled hours to that level, you will become a participant again at that time. Your elections will be reinstated under the same rules for individuals who terminate employment and then are rehired.

C. Unpaid Leave of Absence

Your participation in the Plan will be suspended during the period of an unpaid leave unless you arrange to make after-tax payments for coverage during the absence. Upon return from a leave where coverage was discontinued, you must reenter the Plan on the same basis you were participating in the Plan prior to the leave. With respect to your Health Care FSA, you may either elect to reinstate the coverage level in effect at the commencement of the leave (and pay for any elected amount not paid during the leave) or elect a reduced pro-rated coverage level (that reinstates the per-pay period withholding amount in effect at the commencement of the leave). In neither event may any claims be reimbursed that were incurred during a period in which the coverage was terminated.

V. HEALTH CARE FSA PROGRAM

A. Reimbursements.

As a participant in the Plan, you are eligible to allocate up to $5,000 of your Flexible Benefits Account credits to a Health Care FSA that may be used to reimburse you for qualifying medical expenses (medical, dental, vision, and hearing, as described in paragraph B below) that are not otherwise 100% covered. The amount set aside in the Health Care FSA may generally be used to pay any health care

expenses that would qualify as a medical deduction under the IRS rules except for insurance premiums. However, health care expenses reimbursed through the Health Care FSA cannot be claimed as an additional deduction for income tax purposes.

Qualifying medical expenses incurred during a Plan year will be reimbursed according to the payment provisions described in Section III, paragraph B of this Summary Plan Description to the extent you have a credit balance in your Health Care FSA. For purposes of determining your Health Care FSA credit balance, your employer will calculate the total credits you are to receive for the entire Plan year and will subtract any amounts previously paid to you from the sub-account.

Qualifying Medical Expenses

In order to satisfy the Internal Revenue Code requirements, the reimbursements to be made from the Health Care FSA Program must be limited to qualifying medical expenses you incur either on your own behalf or on behalf of your spouse or a dependent, but not a domestic partner or a child who is not a tax dependent. The term "medical expense" means an expense incurred for medical care that would be deductible under Internal Revenue Code Section 213(d). Sample expenses include deductibles, amounts over the maximum of what insurance will pay, and other qualified expenses not covered by other benefit plans. (See Appendix A for a list of common qualifying medical expenses.) Remember, if you are eligible to make contributions to an individual HSA, you will not be eligible for the Health Care FSA Program.

B. Continuation Coverage.

Continuation Coverage under the Health Care FSA Program is provided under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). "Continuation Coverage" means your right, or your spouse's and dependents' right, to continue the same coverage under the Health Care FSA Program that was in place the day before a Qualifying Event if your (or your spouse's or dependents') participation in the Health Care FSA Program ends as a result of that Qualifying Event.

A Qualifying Event is:

- the termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce from your spouse;
- your becoming entitled to receive Medicare benefits; or
- your dependent's ceasing to be a dependent.

For a Qualifying Event other than a change in your employment status or death, you must inform CNO HR Service Center of the Qualifying Event within 30 days of its occurrence in order to continue this

benefit. CNO HR Service Center in turn, will furnish you (and your spouse, as the case may be) with separate, written options to continue your coverage at the rate in effect at the time of the Qualifying Event. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

You will be eligible for Continuation Coverage only if you have a positive Health Care FSA Account balance at the time of the Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the Health Care FSA Account will cease at the end of the year and cannot be continued for the next Plan year. You must pay premiums for the Continuation Coverage on an after-tax basis.

VI. DEPENDENT CARE FSA PROGRAM

A. Tax Considerations.

Because there is a federal income tax credit available for dependent care expenses, it is not always advantageous for employees to use the Dependent Care FSA because expenses reimbursed through the Dependent Care FSA cannot be claimed for the income tax credit. Complete details about computing the tax credit can be found on IRS Form 2441 and IRS Publication No. 503. There are numerous factors to consider, so you may wish to consult a tax advisor. Expenses reimbursed through the Dependent Care FSA cannot be claimed for an income tax credit. It is also important to realize that not all dependent care expenses are eligible for reimbursement under the Dependent Care FSA.

B. Reimbursements.

As a participant in the Plan, you are eligible to allocate a portion of your Flexible Benefits Account credits to a Dependent Care FSA that may be used to reimburse you for qualifying dependent care expenses (as described in paragraph C below) under the program. Qualifying dependent care expenses incurred during a Plan year will be reimbursed according to the payment provisions described in Section III, paragraph B of this summary to the extent you have a credit balance in your Dependent Care FSA.

In order to satisfy the requirements of the Internal Revenue Code, the maximum amount that you may be reimbursed from this subaccount for any Plan year is the least of:

1. your earned income during that year;
2. your spouse's earned income; or
3. $5,000 ($2,500 if you are married and file a separate federal income tax return).

The Company may require you to submit proof of your or your spouse's earned income and of your tax

filing status to insure compliance with this requirement.

C. Qualifying Dependent Care Expenses.

In order to satisfy the Internal Revenue Code requirements, the reimbursements to be made from the program must be limited to qualifying dependent care expenses you incur on behalf of a dependent (determined under Internal Revenue Code Section 151(c)) who is under age 13 or who is physically or mentally incapable of caring for himself. Only expenses incurred to enable you to work for your employer are reimbursable under the program. Expenses paid to a dependent care center, to a housekeeper whose services include providing care for an eligible dependent, or to someone who is related to you are subject to special rules and may not be reimbursable. Please note that expenses incurred to provide care to a disabled spouse, elderly parent or other qualifying individual who resides with you and is physically or mentally incapable of self-care may also be reimbursable from the program.

VII. INDIVIDUAL HEALTH SAVINGS ACCOUNT PROGRAM

This program allows you to make contributions to an individual HSA if you are an "eligible individual". You are an eligible individual, and can elect to make pre-tax contributions to an HSA through this Plan, if you select the high deductible option through the CNO Care Options Plan, and you do not have other impermissible coverage that would make you ineligible under the IRS rules to contribute to an HSA. (Impermissible coverage includes any other coverage that would pay your medical expenses prior to meeting your deductible under the CNO Care Options Plan). If you are eligible to choose this benefit you may not participate in the Health Care FSA.

VIII. FMLA LEAVE OF ABSENCE

Because your employer is subject to the Family and Medical Leave Act of 1993 (FMLA), if you are on eligible leave under FMLA, then you may choose to revoke your medical, dental and vision coverage and your Health Care FSA benefits during the period of your FMLA leave, and elect to reinstate those coverages upon your return from FMLA leave. Alternatively, you may elect to continue those coverages during the period of your FMLA leave. If you elect to continue your coverages, you must decide how to pay for your coverages while you are on FMLA leave. Under the Plan, you have the following payment options: (1) to pay for your coverage on an after-tax basis, or (2) if offered by your employer, through other arrangements (such as pre-paying on a pre-tax basis through extra salary reductions before you go on leave or continuing your contributions while you are on leave on a pre-tax basis, to the extent you have taxable compensation while on FMLA leave).

Upon return from such leave, you must reenter the Plan on the same basis you were participating in the Plan prior to the leave. With respect to your Health Care FSA, you may either elect to reinstate the

coverage level in effect at the commencement of the leave (and pay for any elected amount not paid during the leave) or elect a reduced pro-rated coverage level (that reinstates the per-pay period withholding amount in effect at the commencement of the leave). In neither event may any claims be reimbursed that were incurred during a period in which the coverage was terminated.

IX. SUPPORTING DOCUMENTS

To view a list of common types of expenses and the required documents needed to support the FSA reimbursements, please visit www.wageworks.com. Please refer to this list before submitting a voucher for reimbursement.

Please note: If you or your spouse do not have any insurance to cover an eligible expense, please indicate this on your claim form, then submit bills and/or documentation of the service provided and date, and cancelled checks to support the expense. Keep in mind that you can only be reimbursed for an expense that is eligible and that was incurred during the Plan year. The expense does not have to be paid before you can be reimbursed. If an expense is incurred in one Plan year but not paid until the next Plan year, the expense is reimbursable from the prior Plan year's account. Cancelled checks and credit card receipts will not be accepted without further documentation as described on the WageWorks website.

X. PLAN AMENDMENT AND TERMINATION

While the Company has no intention of changing or eliminating the Plan or any part of the Plan, it reserves the right to amend or terminate the Plan at any time for any reason in its sole discretion. The Employers reserve the right to terminate their participation in the Plan at any time for any reason in their sole discretion.

XI. CLAIM PROCEDURES

All manual claims for benefits under the Plan must be made in writing and mailed or faxed to WageWorks as described in Section III above.

If a claim for benefits under an insurance policy is denied, in whole or in part, you will need to follow the claims procedures under that policy. If a claim under the Dependent Care FSA Program is denied, you will need to follow the claims procedures of that program. However, if your claim for benefits under the Health Care FSA Program is denied, in whole or in part, the claims procedures described below will apply.

If the Company believes your claim should be denied, you will be notified in writing of the denial within 30

days after the Company receives the claim. This time period may be extended for an additional 15 days for matters beyond the control of the Company, including cases where a claim is incomplete. The Company will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Company is expected to be made. Where a claim is incomplete the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.

The notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision, a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- appropriate information on the steps to be taken if you wish to appeal the Company's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information.

If your claim is denied in whole or part, you (or your authorized representative) may request the Company to review your denied claim. Your request, or "appeal," must be made in writing and given to the Company within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The Company will review all written comments you submit with your appeal request.

Your appeal will be reviewed and decided by the Company in a reasonable time, not longer than 60 days, after the Company receives your appeal request. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of the adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;

- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following an adverse benefit determination on review.

Please review the Plan document for a more detailed description of these procedures and of the Company's and your rights in the event of a claim dispute.

XII. ERISA RIGHTS

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

(1) Examine, without charge, at your employer's office, all documents governing the Health Care FSA Program, including a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(2) Obtain, upon written request to the Company, copies of all documents governing the operation of the Health Care FSA Program, including copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Company may make a reasonable charge for the copies.

(3) Continue Health Care FSA Program coverage under certain conditions for yourself, spouse or dependents if there is a loss of coverage as a result of a Qualifying Event. You or your dependents will have to pay for such coverage. Review the summary plan description and the documents governing the Health Care FSA Program for rules governing COBRA continuation coverage rights.

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

If your claim for a Health Care FSA Program 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 Company 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 Company 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 Company. If you have a claim for benefits, that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that 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 to be frivolous.

If you have any questions about the Health Care FSA Program, you should contact the Company. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Company, 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.

XIII. PRIVACY RIGHTS

The Health Care FSA Program is required to use, disclose, and maintain any medical information that is identifiable to you, called “protected health information” (“PHI”), that it receives, uses, discloses, or creates, in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its related “Privacy and Security Regulations.” The Privacy Regulations also provide that, as an individual covered under the program, you have certain rights to access, restrict, amend, and request an accounting of your PHI held by the program. The program is required to maintain, update, and make available to you, as specified under the Privacy Regulations, a *Notice of Privacy Practices* describing the program’s uses and disclosures of PHI that it may make without your specific authorization.

The Privacy Notice will also describe your individual rights and the program’s legal duties with respect to your PHI held by the program. The Privacy Notice will be made available to you, as an individual covered under the program (1) at the time of enrollment if you are a new enrollee after April 14, 2003; and (2) within 60 days of a material revision of the Privacy Notice, if you are covered under the program at that time. The Privacy Regulations also require that at least once every three years, the program’s Privacy

Officer, who is responsible for the Privacy Notice, notify individuals covered under the program of the availability of the Privacy Notice and how to obtain a copy of the Privacy Notice. The Security Regulations require that the Plan establish and maintain certain administrative, procedural and technical safeguards for PHI that is in electronic form.

XIV. NO PBGC COVERAGE

The Health Care FSA Program is a welfare benefit plan and is excluded from coverage under the plan termination provisions of ERISA. Thus, no insurance coverage is offered through the Pension Benefit Guaranty Corporation (PBGC).

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