2013 Benefits Guide

SUCCESS IS EARNED.

CNO FINANCIAL GROUP

At CNO, we provide a comprehensive suite of health and wellness benefits for our associates and their families. Take time to review your 2013 Benefits Guide, which includes detailed information about each of your CNO benefit options. Keep in mind that this guide is only a detailed summary of our plans and is not intended to replace any plan documents or Summary Plan Descriptions (SPD.)
You can access the SPD for each of CNO's benefit plans at Benefits InfoNet at www.cnoinc.com/benefitsinfonet.aspx.
User ID: cnoinc; Password: benefits

Note: The information in this book highlights key features and is not intended to replace plan documents or Summary Plan Descriptions (SPDs). You may obtain an electronic copy of any SPD for any plan on Benefits InfoNet. You may also request a paper copy of any SPD by contacting the HR Service Center at (888)477-2123.

CNO FINANCIAL GROUP

Getting Started: Eligibility and Coverage Options

Eligibility for benefits

NEW HIRES

Full-time associates: If you're a regular associate and normally scheduled to work a minimum of 30 hours per week, you're eligible for all associate benefit options, including Bankers Life products and individual Washington National Insurance Company products. Eligibility begins on the first day of the month following one full calendar month of employment as a full-time associate.

Examples: If your first day of full-time employment starts on March 1, you're eligible for medical benefits on April 1. However, if your first day of full-time employment is between March 2 and 31, you're eligible for benefits on May 1.

If you don't enroll for benefits when you're first eligible, you may enroll during the next Annual Enrollment period or earlier if you experience a qualifying event.

Part-time associates: If you're a regular associate and normally scheduled to work a minimum of 20 hours per week but less than 30 hours per week, you're eligible to participate in the CNO Wellness programs including the OurClinics@CNO, the Employee Assistance Program (EAP), Bankers Life products and individual Washington National Insurance Company products only. The CNO Wellness programs and EAP are company-provided benefits and no enrollment is necessary. Call (800) 628-6428 to obtain information or enroll in individual Washington National products. Call (765) 289-2264 ext. 150
to obtain information or enroll in the Bankers Life products.

Status changes during the year

If you're an exempt or non-exempt associate and change from less than full-time status to full-time status (30 hours or more per week) during the plan year, your benefits will be effective the first of the month after you have completed one full calendar month of service at the new full-time status, as long as you complete the required online enrollment process within 30 days of your change to full-time status.

If you're an exempt or non-exempt associate and change from full-time status to less than full-time status during the plan year, your benefits will be terminated effective the last day of the month in which the status change occurred. If your benefits are terminated for this reason, you and your eligible dependents will be eligible to elect COBRA continuation coverage for your medical, OurClinics@CNO, dental and vision benefits.

Coverage for your dependents

If you elect medical, dental, vision or supplemental term life/AD&D insurance coverage for yourself, you also may elect coverage for your legally married spouse or same-sex domestic partner. Your legally married spouse does not include a common-law spouse. A common-law spouse is not an eligible dependent under any CNO benefit plan.

To comply with The U.S Patient Protection and Affordable Care Act, the CNO benefit plans extend eligibility to children of participants – regardless of student status, marital status or access to other health coverage – until the dependent's 26th birthday. "Children" are defined as:

- Your biological children, your stepchildren, and children of your same-sex domestic partner if the child resides with you.
- Your legally adopted children.
- Any foster child or child for whom you are the legal guardian pursuant to court order.
- Your children under the age of 26.

Refer to page 22 for eligibility information related to supplemental life insurance for your children.

Same-sex domestic partner eligibility

If you elect to cover a same-sex domestic partner on your benefits, log in to Benefits InfoNet and follow the instructions indicated in the "Domestic Partner Verification Form" under the "2013 Guide and other importance resources" tab. Not all benefits are available to same-sex domestic partners.

No person can be covered as both an associate and a dependent under any CNO benefit plan. In addition, no person can be covered as a dependent of more than one associate under any CNO plan.

Changing benefit elections during the year (Qualifying Events)

Other than during Annual Enrollment, your ability to change benefit elections or coverage levels is limited. Certain changes may be made to your benefits if you experience a qualifying change in status.

You must submit a Qualifying Event within **30 days** from the date of the event. To make your request, go to HR*connect* and click on the "Benefits Enrollment" tab. If you don't submit your request within 30 days of the event, your request will be denied, and your next opportunity to make benefit changes will be during the next Annual Enrollment period.

See your SPD or certificate of coverage for important details on changing benefit elections.

Qualifying Events include:

- Your marriage, divorce, or legal separation.
- The death of a spouse or child.
- The birth or adoption of your child.
- A change in your or your spouse's employment status that affects benefits (e.g. switching from full-time to part-time or termination of the spouse's employment).
- A change in child dependent eligibility.

Note: If you experience a qualifying event that is also a loss of eligibility under the CNO plans (such as divorce, legal separation, or a change in child dependent eligibility), the ineligible individual will lose coverage as of the last day of the month in which eligibility is lost, regardless of whether you submit a Qualifying Event notice. However, if you fail to submit the Qualifying Event notice in a timely manner, you may lose the right to reduce your pre-tax elections for the lost coverage, and you may forfeit the opportunity for the ineligible individual to elect COBRA continuation coverage. For these reasons, it is very important to submit Qualifying Event notices in a timely manner as described in this Guide and your SPDs.

Termination of coverage

Your medical, OurClinics@CNO, dental, vision, EAP and company-paid supplemental term life and AD&D insurance coverage end on the last day of the month in which you terminate employment or become ineligible. Long-Term Disability coverage (both company-paid and the buy-up option) ends the day you terminate employment.

If your coverage terminates under any of your benefit plans due to a termination of employment or loss of eligibility, you may be entitled to continue certain types of coverage for a period of time:

- You and your eligible dependents may be eligible for COBRA continuation coverage for medical, OurClinics@CNO, dental, vision, and EAP coverage if you experience a COBRA qualifying event. If you elect COBRA coverage, you will be responsible for paying the required premiums directly to ADP Benefit Services in a timely manner, as described in your COBRA election notice.

- Coverage under your health care and/or dependent care FSA ends on the last day of the month in which you terminate employment or become ineligible. Reimbursement will be made only for eligible expenses incurred on or before that date. Continuation of your health care FSA beyond that date may be available under COBRA but not past the end of the plan year (December 31) in which your employment ends.

- Supplemental associate, spouse and child term life insurance is portable. You will need to initiate the process of portability within 10 days of your qualifying event. (AD&D coverage is not portable.) Log on to Benefits InfoNet and go to the Forms Library in Knowledgebase to access the "Portability Notice" form.

- If your employment ends for reasons other than retirement, you may convert your long-term disability plan to a CIGNA individual plan. To qualify for conversion, you must have been covered under the LTD policy for at least 12 consecutive months, not be disabled and be less than age 70. CIGNA must receive your conversion application within 60 days from the date of termination. If approved, your conversion insurance will become effective on the date the insurance company agrees in writing to insure you. Applications received more than 60 days from the date of termination will not be considered for approval. Log on to Benefits InfoNet to access the CIGNA LTD Conversion Form.

- Your coverage for individual Washington National and Bankers Life insurance products is portable, so you can continue this insurance protection after your employment ends. If you elect to continue the insurance, you will be responsible for paying the full premium directly to Bankers Life or Washington National.

Pre-tax/after-tax benefits

Premiums deducted for pre-tax benefits reduce your amount of taxable income. Premiums for after-tax benefits are deducted after applicable taxes have been taken from your gross wages. After-tax deductions reduce your net paycheck but do not affect taxable income.

Pre-tax benefits include:

- Medical coverage
- Dental coverage
- Vision coverage
- HSA contributions
- Company-paid term life and accidental death and dismemberment (AD&D) insurance
- Company-paid Long-Term Disability (LTD) benefit
- Flexible Spending Accounts (FSAs)

After-tax benefits include:

- Supplemental associate and spouse term life and AD&D insurance
- Supplemental child term life insurance
- LTD insurance buy-up option
- Washington National Critical Solutions®
- Washington National Worksite Critical Illness®
- Washington National Solutions® Cancer
- Pulse Protection Series®
- Accident Assure®
- Hospital Secure®
- Worksite UL2®
- Washington National Term Life Plus℠
- Bankers Life long-term care

Medical Plan Options with Health Savings Account

Medical plan options: overview

CNO offers two medical plan options – Medical Option 1 and Medical Option 2 - that pair a high-deductible health plan (HDHP) with a Health Savings Account (HSA). You decide whether to use the pre-tax HSA to help pay your current health plan expenses – such as the annual deductible, coinsurance, and prescriptions – or save it for future use.

You can enroll in a medical plan option, even if you don't contribute to an HSA. If you don't choose (or are not eligible) to contribute to an HSA, you can still enroll in either of CNO's medical options to take advantage of the comprehensive medical coverage.

The two medical options have the same structure:

1. You pay out-of-pocket (or from your HSA) until you meet your annual deductible. Remember, if you seek services in-network, your expenses are discounted, reducing your out-of-pocket expenses.
2. Once your deductible is met, the plan shares expenses with you through coinsurance. For example, the plan pays 80% of covered in-network charges, and you pay the remaining 20%, up to the designated out-of-pocket maximum.
3. Once the out-of-pocket maximum is reached, the Plan pays 100% of eligible expenses for the rest of the plan year.

The plan pays 100% for in-network preventive care
Preventive care is strongly encouraged and paid at 100% under both medical plan options if you use in-network providers. Additionally, preventive care services are available free of charge at OurClinics@CNO, located in Carmel, Chicago, and Philadelphia. Refer to the **CIGNA networks** section of this book for more information about CIGNA's networks.

Remember, CNO provides Generic Preventive Maintenance (Generic PM) medications at no cost to you if you obtain your medications from CIGNA Home Delivery or through one of OurClinics@CNO.

Refer to the prescription drug coverage section of this book for more information.

How do I use my CNO medical coverage?

- When you receive services from an in-network medical provider, show the provider your CIGNA ID card. (Note: If you receive services from an in-network physician who requires payment upfront, confirm that the provider has verified your benefits with CIGNA and applied all network discounts when determining the final amount you owe.)
- The provider will submit the claim to CIGNA, who processes the claim and issues an Explanation of Benefits (EOB) to the provider. The EOB summarizes the billed and discounted amounts, the amount the plan will pay and the amount (if any) you owe the provider. All non-preventive covered expenses apply to your deductible and out-of-pocket maximum.
- If you owe the provider payment for a claim, you determine whether to use your HSA funds or save them for future expenses. Once your deductible is met, claims are paid by the CNO Care Options Plan according to the terms outlined in the Medical Plan options table.

Note: If you receive services from an out-of-network provider, you may be required to pay in full when you receive services and then submit a claim for reimbursement. The plan will reimburse covered out-of-network claims according to it's stated terms.

In all cases except preventive care, deductibles must be met before the plan begins paying.

Refer to page 9 for detailed information about using your HSA with your medical coverage.

Health Savings Account (HSA) overview

An HSA is an individual account you can use to pay for qualified health expenses for yourself and your tax dependents.

An HSA offers two advantages for you:

1. Unlike traditional tax-advantaged accounts for health expenses (such as a Health Reimbursement Account or a Flexible Spending Account), your HSA belongs to you. If you leave the company, you take the funds with you.
2. All deposits made by you and/or CNO are tax-free. This reduces your taxable income and potentially, your tax liability. Additionally, when you use the funds for qualified medical expenses, the withdrawal is also tax-free.

You can contribute to an HSA only while you're covered by a high-deductible health plan and don't have other first-dollar health coverage. Consult your tax advisor to determine how your HSA affects your tax circumstances. If you use your HSA funds for non-qualified expenses, the amounts are taxable and you are required to pay an additional 20 percent tax penalty on the withdrawn amount.

Refer to page 9 for detailed information about using your HSA with your medical coverage.

How does my HSA work with my medical coverage?

CIGNA has partnered with JPMorgan Chase to provide custodial services for all HSAs that work in conjunction with CNO's medical plan options. You can contribute pre-tax dollars to your HSA through payroll deductions. By completing wellness activities, you also can earn company contributions into your HSA (see page 15 for information about incentives). You, CNO and/or anyone you designate can deposit money in this HSA up to the IRS annual maximum to pay for qualified medical and prescription drug expenses. This information applies for both CNO medical plans.

Medical plan options table

Both medical options are supported by the CIGNA Open Access Plus network.

Medical plan features	Medical Option 1		Medical Option 2	
Health Savings Account (See page 8 for HSA Contribution limits)	**POTENTIAL CNO CONTRIBUTION**[1] Associate: $1,000 Associate + child(ren): $1,500 Associate + spouse: $1,500 Family: $2,000			
Preventive care	100% payable by the Plan (including annual exam, routine mammogram, Pap, PSA, immunizations, annual eye exam, etc.)			
Calendar-year deductibles	**IN-NETWORK** $2,500 Associate $3,750 Limited family $5,000 Family	**OUT-OF-NETWORK** $5,000 Associate $7,500 Limited family $10,000 Family	**IN-NETWORK** $1,750 Associate $2,625 Limited family $3,500 Family	**OUT-OF-NETWORK** $3,500 Associate $5,250 Limited family $7,000 Family
Coinsurance	In-network: 80% of allowable charges covered after deductible Out-of-network: 50% of allowable charges after deductible			
Specialists[2] **CCN = CIGNA Care Network; INN = In-network, non-CCN**	80% CCN or 70% INN of allowable charges covered after deductible Out-of-network: 50% of allowable charges after deductible[3]			
Prescription drugs (see page 9 **for details)**	Generic PM: 100% payable by the Plan | Tier 1 through 3: After deductible you pay: Tier 1: 20% up to $15 | Tier 2: 40% up to $50 | Tier 3: 60% up to $100 *There are no out-of-network benefits for prescription drugs.			
Annual out-of-pocket maximum	**IN-NETWORK** $5,000 Associate $7,500 Limited family $10,000 Family	**OUT-OF-NETWORK** $10,000 Associate $15,000 Limited family $20,000 Family	**IN-NETWORK** $4,000 Associate $6,000 Limited family $8,000 Family	**OUT-OF-NETWORK** $8,000 Associate $12,000 Limited family $16,000 Family
Semimonthly premiums Associate Associate + child(ren) Associate + spouse Family	 $41.50 $127.00 $149.50 $189.50		 $73.50 $182.50 $215.50 $272.50	

[1] CNO-provided HSA funds are earned when you complete wellness tasks. See page 15 for details.
[2] CNN/INN coinsurance differentials apply only to specific specialties.

Out-of-area medical plan option

If you live in an area where there is no CIGNA Open Access Network availability, you will be enrolled in the Medical Option 1 – Out of Area Plan. This option has the same features as Medical Option 1 (Refer to page 7), but in-network benefit levels are provided for covered medical services from any physician regardless of their network status. If an associate receives covered medical services from an in-network physician, service fees are discounted, reducing the out-of-pocket expense.

2013 HSA contribution limits

A maximum of $3,250 annually (associate-only coverage) or $6,450 annually for the other three levels of coverage may be contributed to your HSA.[1] Refer to the following table for maximum CNO and associate HSA contributions for 2013.

"Catch-up" contributions are available for participants age 55 and older. Catch-up contributions permit you to contribute an additional $1,000 to an HSA annually. To make pre-tax catchup contributions through payroll deductions, you will need to complete the HSA Catch-up Deduction Form on Benefits InfoNet or you can make after-tax deposits directly to your HSA.

Coverage tier	CNO potential HSA contribution	Associate maximum HSA contribution (via payroll deduction)[2]	Total HSA contribution limit[1]
Associate	$1,000	$2,250	$3,250
Associate + Spouse	$1,500	$4,950	$6,450
Associate + Child(ren)	$1,500	$4,950	$6,450
Family	$2,000	$4,450	$6,450

1 You may contribute the annual maximum even if you become eligible midyear. However, midyear HSA participants must remain enrolled in the high-deductible health plan for the entire calendar year following enrollment. If you don't maintain coverage for that period, you'll be required to pay income tax plus a 20% penalty on your excess contributions made.

2 These amounts are the maximum associate HSA contribution through payroll deduction. If you don't earn the maximum CNO contributions for completing wellness tasks, and you want to contribute to your account to reach the total HSA contribution limit, you can make after-tax deposits to your HSA until you reach your HSA contribution limit, which should be deductible on your individual tax return.

HSA advantages

- Withdrawals from your HSA to pay for qualified medical expenses (including medical, dental, and vision) are tax-free. Click here for a list of HSA eligible expenses or refer to IRS Publication 502 – Medical and Dental Expenses.
- Unused HSA funds accumulate year to year. If you leave the company or terminate this benefit for any reason, you keep your funds.
- The HSA is an individual account and is yours to keep. It's available to spend on non-health purchases on a taxable basis, but additional penalties may apply. See your tax consultant for information.

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

- You must be enrolled in a high deductible health plan (HDHP) such as one of CNO's medical plan options that meets the IRS requirements.
- You cannot be covered by another health plan that is not an HDHP. For example, you can't be a dependent on anyone else's health plan unless it's a qualifying HDHP, with the exception of plans that provide only first-dollar preventive care, vision or dental coverage.
- You can't be enrolled in Medicare or Medicaid.
- You can't be claimed as a dependent on another persons' tax return.
- Your health claims may not be eligible for reimbursement under any "general purpose" health care FSA (including your spouse's FSA).
- You can't be enrolled in TRICARE coverage.
- You can't have received VA Medical coverage within 3 months from the time of your HSA enrollment, unless covered services were only for dental, vision or preventive care coverage.
- You may not be enrolled in any "Mini-Med" or supplemental health insurance policies that provide significant medical benefits for specified medical services like organ transplant, ER, hospitalization, outpatient treatment, or ambulance services. Note: Specified disease (e.g. cancer), and hospital indemnity policies that are limited to a fixed amount per day, don't disqualify you from HSA coverage. (Coverage under Bankers Life and Washington National supplement products offered to associates don't disqualify you from HSA coverage.)

If I am not eligible for an HSA, can I still earn CNO wellness incentives?

Yes. If you're not eligible to contribute to an HSA for one of the reasons listed above, you need to complete an affidavit during Annual Enrollment attesting to the reason that you're not eligible. Then you may elect to establish a general purpose health care FSA and any CNO wellness incentives earned will be deposited into the your health care FSA.

Where can I view my JPMorgan Chase HSA balance?

Log in to mycigna.com and click on 'Manage Claims and Balances' then select 'Health Savings Account' to access your JPMorgan Chase HSA.

Prescription drug coverage

Prescription drug coverage is managed and administered by CIGNA for the CNO Care Options Plan.

Prescription drug definitions

For all plan options, the amount you pay for prescription drugs depends on the type of drug you receive.

- **Generic –** prescription drugs that are not protected by trademark registration. CNO's Tier 1 includes generic drugs. Generic drugs are the least expensive.
- **Generic Preventive Maintenance (Generic PM) -** includes generic drugs prescribed to prevent the occurrence of a disease or condition (e.g. high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke,or a prenatal nutrient deficiency). This includes coverage of preventive maintenance drugs as a result of the Patient Protection and Affordable Care Act for women's health needs. Refer to CIGNA's Drug List on mycigna.com for a list of drugs in Tier 1 with a "PM" after the drug name.
- **Tier 1 -** includes all generic drugs. Some brand-name drugs are also approved for Tier 1.
- **Tier 2 -** includes commonly used brand-name drugs that are not available in a generic form. These drugs are selected for their ability to meet patient needs at a lower cost.
- **Tier 3 -** includes brand-name drugs that have the highest level of cost to the patient.

How do the prescription drug benefits work?

Prescription drug benefits work the same for all medical options as follows:

- Generic PM medications are paid 100% if obtained through CIGNA Home Delivery or from one of OurClinics@CNO. Generic PM drugs related to women's health needs under the Patient Protection and Affordability Care Act are also paid at 100% when obtained from a retail pharmacy. All other Generic PM medications related to chronic health conditions are subject to the Tier 1 deductible and coinsurance when obtained from a retail pharmacy.
- For Tier 1, Tier 2, and Tier 3, you pay 100% of the discounted cost until your deductible is met. After your deductible is met, coinsurance applies as well as the per-prescription, out-of-pocket maximums, as indicated in the Medical plan options table on page 7.

You can pay for prescriptions with HSA funds

You have the option of using your available HSA funds to help you pay for your prescription expenses. Prescription drugs are not covered outside the CIGNA pharmacy network and OurClinics@CNO.

How can I take advantage of the Generic PM benefit? To receive a Generic PM medication at no cost you may obtain it from CIGNA Home Delivery or from one of CNO's onsite clinics (OurClinics@CNO). You can set up CIGNA Home Delivery for a 90-day supply of medications by calling CIGNA at (800)285-4812.

Are all generic medications free? No, only generic prescriptions that are for preventive maintenance medications, which are obtained through CIGNA Home Delivery or from one of OurClinics@CNO will be provided at no cost to participants (except for certain generic PM prescriptions for women's health needs under the Patient Protection and Affordabilty Care Act, which can be obtained at no cost at a retail pharmacy). 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 deductible and co-insurance.

What if 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 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.

Where to get more information about prescription drugs

Information on prescription drugs covered by the CNO Care Options Plan is available in the SPD on Benefits InfoNet. You also may request information by calling CIGNA toll-free at (800) 244-6224 or going to mycigna.com.

Information on prescription drugs available at OurClinics@CNO is available at the OurHealth portal https://portal.ourhealth.org.

Other important medical coverage information

Will a pre-existing limitation apply to me?

As a result of the Patient Protection and Affordable Care Act, no pre-existing condition limitations are applied to plan enrollees age 18 or younger.

If you're 19 years or older and have been continuously covered under another qualified medical plan before becoming eligible for a CNO plan option, pre-existing limitations will not apply.

If you're 19 years or older and have had a break in coverage of 63 or more days just before becoming eligible for coverage under the CNO Care Options Plan, there may be a period of time during which charges for treatment of the pre-existing condition are not reimbursable. Contact CIGNA customer service for more details.

How can I ensure that I'm billed correctly for medical services?

You can take several steps to ensure you're billed correctly for medical services.

1. Whenever possible, use in-network providers. In most cases, you will not be required to pay at the time of service. (Note: If your in-network physician requires payment upfront, confirm that the provider has verified your benefits with CIGNA and applied all network discounts when determining the final amount you owe.)
2. The provider will submit your claim to CIGNA, who processes the claim and sends an EOB to you and to your provider with detailed information about your claim and all associated costs. For the 21 specialties listed on page 11, you must use a CIGNA Care Network specialist to receive the highest level of in-network coverage. If you receive services outside the Open Access Plus network, you may have to pay in full at the time of service and submit a claim for reimbursement.
3. Keep track of your claim activity at mycigna.com. You can register for an account and then view your claims activity and EOBs. If you owe your provider payment, you decide whether to use your available HSA funds or to save them for future expenses.
4. If you are enrolled in the CNO Care Options Plan and aren't sure of how to access benefits, call CIGNA *before* you receive services.

CIGNA networks

What is the Open Access Plus Network?

Medical Options 1 and 2 are part of the CNO Care Options Plan supported by CIGNA's Open Access Plus network. You receive the highest level of benefits and lower out-of-pocket expenses when you receive care from in-network providers. (Refer to the CCN section below for information about certain physician specialists.) You may use out-of-network providers, but benefits are reduced and out-of-pocket expenses are higher and you may be required to submit claims for reimbursement.

What is the Cigna Care Network (CCN)?

CCN is a program that helps associates choose the best healthcare providers for various medical specialties. The CCN designation is given to participating doctors who meet quality and efficiency standards. CCN designations apply to the following specialties:

- Allergy/immunology
- Cardiology
- Cardiovascular surgery
- Colon and rectal surgery
- Dermatology
- Endocrinology
- Gastroenterology
- General surgery
- Hematology/oncology
- Infectious disease
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics/gynecology
- Ophthalmology
- Orthopedics
- Otolaryngology (ear, nose, throat)
- Pulmonary medicine
- Rheumatology
- Urology
- Vascular surgery

If you need care in one of these specialties, your benefits will depend on your choice of specialist:

- If you receive covered services from a CCN-designated specialist, you'll receive the highest level of in-network benefits as stated in the **Medical plan options table** on page 7.
  - If you receive covered services in a specialty listed above from a CIGNA Open Access Plus doctor who does not the CCN designation, you'll receive the lower level of in-network benefits as stated in the **Medical plan options table** on page 7.
  - If you receive covered services in a specialty listed above who is not a CIGNA participating doctor, you'll receive benefits at the out-of-network coverage level as stated in the **Medical plan options table** on page 7.

A doctor's CCN designation can change. CIGNA reevaluates providers once each year. Evaluations are in effect from January 1 through December 31. Before seeing your doctor, check the provider directory at cigna.com to determine whether the provider is designated as a CCN specialist.

How do I find a doctor in CIGNA's Open Access Plus network?

1. You have access to CIGNA's Open Access Plus network of physicians and facilities no matter which medical option you choose. You are responsible for verifying that your physician or specialist is an in-network provider before you enroll for Medical Option 1 or 2.

2. Log in to cigna.com to find doctors who are participating in the CIGNA Open Access Plus or CCN networks.
   - On the main page, enter your location information in the "Find a Doctor" section.
   - Select the "Open Access Plus ONLY" plan type.
   - Select the type of primary care physician or specialist.
   - Click "Search."
   - To identify a CCN specialist, look for the CCN designation on the search results screen.

3. If you have any questions or need help locating in-network providers, contact CIGNA's customer service (800) 244-6224.

Your Other Benefits

Consumer Tools

Castlight

Castlight Health, is an online, telephonic, and mobile tool that helps you find high-quality medical care and see how much you will pay for it before you go. Castlight Health makes it easy to compare your options on cost, quality, and convenience so you can make smart health care decisions for your family.

Using Castlight, you're able to:

- Compare in-network doctors and medical services in your area based on the price you'll pay and quality of care other patients have received.
- See personalized cost estimates before you go to the doctor that take into account your health plan and whether you've already met your deductible.
- Review step-by-step explanations of past medical spending so you know how much you paid and why.
- Receive recommendations about ways to save money and find high-quality care.

In January 2013, associates will be able to register for Castlight Health services at www.castlighthealth.com/register.

CNO wellness

Each of us is in a different place on the path to better health. That's why CNO offers the For Your Health! wellness program. The program provides wellness opportunities for all associates, as well as family members enrolled in a medical plan option under the CNO Care Options Plan. Plus, the programs can help participants in the CNO Care Options Plan earn company contributions to their HSA or health care FSA. (Refer to "incentives" section for information.)

OurHealth

CNO partners with OurHealth, an independent provider of on-site health management services, to support CNO's For Your Health! wellness program. OurHealth provides a variety of wellness resources to associates listed below.

OurClinics@CNO

CNO has on-site clinics in our three main office locations of Carmel, IN, Chicago, IL, and Philadelphia, PA. The clinics provide convenient, affordable access to certain health care services. Clinic staffing and office hours vary by location, but include either a doctor or nurse practitioner along with two licensed practical nurses, and a health coach for office hours during the work week. All associates are eligible to use the on-site clinics. Family members age 13 and older who are covered under the CNO Care Options Plan are also eligible to use the clinics. The clinics provide the following services:

- **Acute and Primary Care –** Medical services include primary, preventive, and urgent care medical services (i.e. annual physicals, treatment of common conditions and minor injuries, and chronic health management.)
- **On-site Prescription Dispensing –** The clinic will dispense more than 65 generic prescriptions to treat illnesses diagnosed at the clinic. Prescriptions from outside physicians may also be obtained in the clinic, after consultation with an on-site health care professional.
- **On-site Lab Work –** Routine lab tests may be obtained at the clinic, including those ordered by an outside physician.
- **Preventive Health Screenings –** Clinic staff will be available to conduct initial preventive health screenings, complete follow-up consultations to discuss results, and develop an action plan to help you maintain or improve your health status. Associates and their family members can utilize the clinic to obtain their biometric screenings in order to earn CNO's wellness incentives. (Refer to the wellness incentives at page 15.)
- **Personal Health Coaching –** Face-to-face individual and group health coaching will be offered at the clinic and can apply towards earning CNO wellness incentives. (Refer to the wellness incentives at page 15.) Health coaches can assist participants by creating personalized, targeted wellness plans with achievable health goals. Health coaching can help participants manage chronic health conditions (i.e. blood pressure management, cholesterol management, diabetes, and heart disease.) It can also assist with lifestyle management coaching (i.e. nutritional counseling, stress management, tobacco cessation, and weight management.)
- **FUSE Weight Management Program –** This free, 12-week, onsite weight management program is open to all associates (regardless of medical plan enrollment). The program, developed and led by OurHealth physicians, nurses, and health coaches, guides participants through group and one-on-one sessions focused on weight management tools and resources and the creation of a sustainable lifestyle action plan.
- **Value Based Referrals –** Clinic professionals will provide recommendations for referrals to a specialist, or other services not offered by the clinic.

OurClinics@CNO provide real cost savings for associates.

All preventive care services and generic preventive maintenance drugs (Generic PM) dispensed at the clinic are provided at no cost to participants.

Because of the clinic's lower fixed-cost model, it provides lower out-of-pocket cost for associates and family members receiving non-preventive care services. The fee schedule for nonpreventive care services offered by the clinics is:

- Routine office visit - $25
- Prescription - $4

The Clinic provides real convenience for associates

Associates can schedule appointments online through the OurHealth portal at https://portal.ourhealth.org, by phone, or at the clinic. Same day appointments are reserved for more urgent requests.

OTHER PROGRAMS SUPPORTED BY OurHealth

Phone coaching programs (custom tailored to each participant's condition and health needs)

OurHealth also supports telephonic health coaching. Telephonic health coaching is available to all associates and any adult dependent enrolled in the CNO Care Options Plan. OurHealth's coaches will work with participants to address specific health concerns and create a personalized, targeted wellness plan with achievable health goals. Health coaching can help participants manage chronic health conditions (i.e. blood pressure management, cholesterol management, diabetes, and heart disease.) It can also assist with lifestyle management coaching (i.e. nutritional counseling, stress management, tobacco cessation, and weight management.) To enroll in telephonic health coaching, contact OurHealth at (866) 434-3255 or through the OurHealth portal https://portal.ourhealth.org.

Online programs (self-paced)

Through the OurHealth portal, all associates and any adult dependents on the CNO medical plan have access to online health programs to help them manage and improve their health. Online health programs include:

- Cholesterol management
- Depression
- Insomnia management
- Chronic Pain management
- Chronic condition management
- Nutrition
- Diabetes management
- Binge eating
- Stress management
- Tobacco cessation
- Blood Pressure management
- Weight management
- Physical activity
- Back pain management

OurHealth Portal

The OurHealth portal includes information about all OurHealth services:

- OurClinic@CNO – including office hours by location, scheduling tools, list of available generic medications, and a list of services
- Online programs
- Health assessment (HealthMedia Succeed Health Assessment)
- Wellness incentive tracker
- Step-by-step fitness tracker
- Frequently asked questions
- Clinic staff biographies
- Other resources
- Privacy information

OurHealth Privacy and Confidentiality Information

The confidentiality of any information you provide to OurHealth is protected by the federal Health Insurance Portability and Accountability Act (HIPAA), as well as the contract between CNO and OurHealth (the clinic owner and manager). One of the reasons CNO chose to contract with OurHealth is to protect employees' privacy. Just like your doctor would not share information with CNO without your consent, OurHealth will not disclose information about any individual without the consent of the individual or his or her authorized representative except as authorized by HIPAA.

OTHER CNO WELLNESS PROGRAMS

Gateway to Health

Gateway to Health is an online portal with a social tracking tool that uses creative ways to help people live a healthy lifestyle. The Gateway to Health portal is used for many of CNO's non-incentive wellness challenges, and it also features a tracker that allows users to enter their daily activity and monitor ongoing progress. To learn more about this program, and to get started go to www.cnoinc.com/wellness.

WalkingSpree

WalkingSpree is a cutting edge program that uses a USB-based pedometer to track your steps walked, distance walked, fat burned and calories burned. After you register for this program, CNO provides an initial pedometer to you, your spouse and any adult child enrolled in the CNOCare Options Plan.

Your (and/or your spouse's) tracked activity in WalkingSpree can help you earn wellness incentives. To register for a new WalkingSpree membership, go to www.walkingspree.com/register/conseco. Your pedometer is mailed to you with account activation instructions within 3-5 business days.

CIGNA Health Programs

As a CNO medical plan participant, you also have access to these CIGNA-sponsored programs:

- **Healthy Pregnancies, Healthy Babies:** Access to continuous support from a nurse who can help you with tips on handling pregnancy discomfort, eating healthy, delivery options, birthing classes and maternity benefits. If you and/or your spouse qualify to enroll in this program, you can earn an HSA incentive for your participation. Call (800) 615-2906 to enroll in the program.
- **Cigna Healthy Steps to Weight Loss:** Work with a wellness coach online or on the phone and access a set of tools and resources to help you find and achieve a sustainable, healthy weight. You'll complete educational modules, which provide preventive care, coping techniques, guidance on controlling your weight, eating healthier and improving your overall health. To enroll and to reach a wellness coach call (866) 417-7848.
- **Cancer Support Program (not incentive eligible):** This program offers support to those facing all types of cancer, based on the participant's needs. To learn more about the Cancer Support Program call (800)CIGNA24.
- **24-Hour Health Information Line (not incentive eligible):** Call the health information line and get live support 24 hours a day, 7 days a week from a registered nurse at (800)CIGNA24.
- **CIGNA Home Delivery (not incentive eligible):** Get up to 90-day supplies of prescriptions in one refill. Log in to mycigna.com and visit the Prescription Drug Price Quote tool on the pharmacy home page; or call (800) 285-4812.
- **CIGNA CoachRx (not incentive eligible):** CoachRx is a free service available to CIGNA Home Delivery pharmacy customers. You can set up daily reminders to take your medications, receive a free pill box to organize your medications, receive reminders for medical appointments and more. Call (800) 835-8981 or visit cigna.com/coarchrx.

Weight Management Programs

CNO also offers associates access to two onsite weight management programs for associates located in Carmel, Chicago, and Philadelphia: OurHealth's FUSE weight management program and the Weight Watchers@Work program.

In addition, associates may earn wellness incentives for participating in one of the following weight management programs:

- **FUSE:** Call OurHealth at (866) 434-3255 for more information.
- **Weight Watchers:** Register online at https://wellness.weightwatchers.com. Enter the company name **CNO Financial Group**, ID **38791,** and passcode **WW38791**)
- **Jenny Craig:** Call (877) JENNY70 for more information.
- **Cigna Healthy Steps to Weight Loss:** Call (866) 417-7848 to enroll.

To receive a quarterly incentive for participation, associates must complete an attendance as proof of attendance in at least nine group meetings during the calendar quarter. The proof of attendance form is available from the For Your Health! page on CNOnet.

How are company-provided HSA incentives deposited into my account?

CNO will deposit funds into your HSA for you (and your spouse if applicable) as a reward for completing wellness tasks throughout 2013. The table below describes all available wellness activities for which you can earn company-provided HSA funds in 2013.

Getting Started category: These tasks set a baseline for your current health status. The wellness incentive is awarded for completing the activity.

Biometrics category: If you achieve the healthy biometric, the wellness incentive is awarded. If attaining healthy biometric results in any of these categories is unreasonably difficult or medically inadvisable for you, you will still be eligible to earn these incentives through alternate activities or programs, as detailed in the HSA menu listed below.

Healthy Activities and Consumerism categories: By completing these tasks, you can earn additional CNO-provided HSA funds (up to the annual maximum) throughout 2013.

			ASSOCIATE INCENTIVES		SPOUSE INCENTIVES	
	Incentive description	Frequency	Incentive amount	Maximum annual incentive opportunity	Incentive amount	Maximum annual incentive opportunity
Getting Started	Health Risk Assessment (HRA)	Annual	$200	$200	$100	$100
	Annual Physical – self	Annual	$350	$350	$175	$175
	Annual Physical – child	Annual	$175	$175	$0	$0
Biometrics	Body Mass Index (BMI) 18.5 – 24.9	Annual	$100	$100	$50	$50
	BMI Improvement > = 10%	Annual	$100	$100	$50	$50
	Blood Pressure < 120/80	Annual	$100	$100	$50	$50
	Cholesterol LDL < = 130 mg/dL	Annual	$100	$100	$50	$50
	Blood Sugar-Hemoglobin A1c < 6.5%	Annual	$100	$100	$50	$50
Healthy Activities	Health Coaching (Face-to-Face or Telephonic)	Quarterly	$100	$400	$50	$200
	Wellness Online Program	Maximum of 4	$20	$80	$10	$40
	Physical Activity: Fitness Tracker, Gateway to Health, or WalkingSpree	Quarterly	$100	$400	$50	$200
	CIGNA Healthy Pregnancy, Healthy Babies	1 per family	$60	$60	$60	$60
	Weight Management Program	Quarterly	$50	$200	$25	$100
Consumerism	Castlight Registration	Annual	$50	$50	$25	$25
	Castlight Search	Annual	$50	$50	$25	$25

Wellness Time Off: By completing the Health Risk Assesment (HRA) and biometric testing (each of the following four tests: BMI, blood pressure, LDL Cholesterol, and Blood Sugar-Hemoglobin A1c), you can earn four hours of wellness time off for use by the end of calendar year 2013 (unused wellness time off does not roll over).

MAXIMUM 2013 COMPANY-PROVIDED HSA CONTRIBUTIONS FOR COMPLETING VARIOUS WELLNESS TASKS

Wellness Programs and Other Programs – Activity requirements for earning incentives:

- **Health Coaching –** The participant must actively participate in either face-to-face health coaching at a OurClinic@CNO location or in telephonic health coaching with OurHealth. To earn the quarterly incentive, the participant must achieve an agreed-upon health goal set with the OurHealth coach. The OurHealth coach will update the OurHealth portal when a quarterly incentive has been achieved.
- **Wellness Online Program –** The participant will earn the incentive upon completion of an online program. Although the participant may complete as many online programs as they want during the year, CNO wellness incentives will only be awarded for the first four programs completed during the year.
- **Fitness Tracker, Gateway to Health Tracker, or Walking Spree –** The participant must log at least 30 minutes of activity or 7,000 steps for 60 days in a quarter to earn the quarterly incentive.
- **CIGNA Health Pregnancies, Healthy Babies –** The participant must enroll and complete CIGNA's Healthy Pregnancies, Healthy Babies program to receive this incentive. In addition to CNO's wellness incentive, the participant will also earn an award from the program - $150 if you enroll by end of your first trimester or $75 if you enroll by the end of your second trimester.
- **Weight Management Programs –** Participants may earn quarterly wellness incentives for participating in FUSE, Weight Watchers, Jenny Craig, or the CIGNA Weight Management Program. To receive a quarterly incentive for participation, participants must complete an attendance as proof of attendance in at least nine group meetings during the calendar quarter. The proof of attendance form is available from the For Your Health! page on CNOnet.
- **Castlight –** Participants may earn annual wellness incentives for registering in the Castlight tool and also for performing at least one search using the tool.

Coverage tier	Potential 2013 HSA incentives for completing wellness tasks
Single	Up to $1,000
Associate + spouse	Up to $1,500
Associate + child(ren)	Up to $1,500
Family	Up to $2,000

Once I complete a wellness task, when will I receive my HSA incentive?

Wellness incentives are funded monthly based upon activity earned through the 15th of each month. For example, wellness incentives earned February 16th through March 15th, are deposited in your HSA by the end of March. You can view your HSA balance by logging into mycigna.com and clicking on 'Manage My Claims and Balances' and then selecting 'Health Savings Account' to view your account activity.

If I am enrolled in a CNO Care Options Plan medical option, but I am not eligible to contribute to an HSA, can I still receive wellness incentives?

Yes. You need to complete an affidavit during Annual Enrollment attesting to the reason that you're not eligible to contribute to an HSA and then you can enroll in a health care FSA to receive CNO wellness incentives. By doing both of these steps, any CNO contributions that you earn will be deposited into a health care FSA for your use in 2013.

Note: You need to actively elect a health care FSA during Annual Enrollment and contribute a minimum of $10 per month to open your health care FSA account. Refer to the FSA section of this Guide for more information.

Your Dental Coverage

Dental plan features	CIGNA Dental Care DHMO	DeltaPreferred PPO	DeltaPreferred Passive PPO
Network coverage	CIGNA DHMO network No out-of-network coverage	DeltaPreferred network Out-of-network coverage – lower benefit levels apply	DeltaPreferred network Out-of-network coverage – benefits covered at in-network level regardless of dentist's status in DeltaPreferred network*
PREVENTIVE AND DIAGNOSTIC • **Oral exams** (two per year) • **Routine cleanings** (two per year) • **Full mouth X-rays** (one complete set every three years) • **Bitewing X-rays** (two per year) • **Panoramic X-rays** (once every three years)	100%	In-network: 100% Out-of-network: 80% after deductible	
• **Fluoride treatments** • **Sealants**	• Once every six months for persons under age 19 • Reduced, fixed, preset charges for all covered services	• Twice per year for persons under the age of 19 • Covered for first molars through the age of 8 and second molars through the age of 13; one treatment per tooth, per lifetime	• Twice per year for persons under the age of 19 • Covered for first molars through the age of 8 and second molars through the age of 13; one treatment per tooth, per lifetime
ANNUAL DEDUCTIBLE **Individual** **Family**	 None None	 In-network: $50 Individual | $150 Family Out-of-network: $100 Individual | $300 Family	 $50 Individual | $150 Family
Calendar-year maximum	Unlimited	In-network: $1,500 per member Out-of-network: $500 per member	$1,500 per member
Basic restorative care	Reduced, fixed, preset charges for all covered services	In-network: 80% after deductible Out-of-network: 60% after deductible	80% after deductible
Major restorative care	Reduced, fixed, preset charges for all covered services	In-network: 50% after deductible Out-of-network: 40% after deductible	50% after deductible
Orthodontia	Reduced, fixed, preset charges for all covered services	In-network: 50% up to $1,000 lifetime maximum for dependent children up to the age of 19 Out-of-network: 40% up to$500 lifetime maximum for dependent children up to the age of 19	50% up to $1,000 lifetime maximum for dependent children up to the age of 19
SEMIMONTHLY DENTAL RATES **Associate** **Associate + child(ren)** **Associate + spouse** **Family**	 $ 5.55 $ 9.19 $ 8.33 $ 15.67	 $ 4.03 $ 13.03 $ 9.25 $ 24.89	 $ 12.12 $ 28.63 $ 23.73 $ 49.39

* Although you'll receive in-network coverage levels even if your dentist is not in the DeltaPreferred network, you may be billed by the dentist for all charges above usual and customary rates (UCR), and are responsible for any amounts over Delta's UCR limit.

How does the CIGNA Dental Care (DHMO) work?

- There are no claim forms to file.
- There is no deductible.
- There is no annual benefit maximum.
- Covered exams, X-rays and routine cleanings are available at no cost to you and your dependents.
- Specialty care is available with a referral.
- No out-of-network benefits are available.

You must select a primary care dentist with this option. For a list of member dentists, visit cigna.com or contact CIGNA at (800) 367-1037.

The availability of network providers is limited. You must verify the availability of participating dentists and confirm that they are taking new patients before you enroll in this option. (If you are not an existing patient of the dentist you choose, consider scheduling an appointment for a simple cleaning as soon as possible to ensure you're on the patient roster. Otherwise, you risk not being able to get in with a DHMO dentist when you need care.) When enrollment ends, you can't change your dental plan option until the next Annual Enrollment period unless you experience a qualifying event, even if you later find that a DHMO network provider is not available in your area.

How does the DeltaPreferred PPO work?

- You have the freedom to select any licensed dentist. Your benefits are greater if you see a DeltaPreferred PPO dentist.
- A deductible applies for basic or major restorative care. The plan pays a percentage of covered charges after the deductible. (See the Dental plan features table on page 17.)
- You don't need to designate a primary care dentist.
- There is no referral requirement for specialty dental work.
- Pretreatment reviews, or predeterminations, are recommended but not required for certain procedures to avoid unplanned expenses.

You must verify the availability of participating dentists before you enroll in this option. When enrollment ends, you can't change your dental plan option until the next Annual Enrollment period, unless you experience a qualifying event.

How does the DeltaPreferred Passive PPO work?

- You may visit any licensed dentist or specialist of your choice.
- Your coinsurance percentages are the same regardless of the dentist you visit. However, if you visit a DeltaPreferred dentist, your fees are discounted, reducing your out-of-pocket expense.
- The plan pays a percentage of covered charges, up to the usual and customary rates (UCR) in your area.
- A deductible must be met for basic or major restorative care. The plan pays a percentage of covered charges after the deductible. (See the Dental plan features table on page 17.)
- You can see any licensed dentist. If you see a dentist who is contracted under DeltaPreferred, the dentist will not bill you for any charged amount that exceeds Delta's UCR limits and you will not have to file a claim form.
- If you see a dentist who is not contracted with DeltaPreferred, your coverage levels remain the same. However, you will be billed by the dentist for all charges and are responsible for any amounts over Delta's UCR limit. In most cases, you will have to file a claim form.
- Pretreatment reviews, or predeterminations, are recommended (but not required) for certain procedures to avoid unplanned expenses.

When enrollment ends, you can't change your dental plan option until the next Annual Enrollment period unless you experience a qualifying event.

How do I access my dental benefits?

CIGNA DENTAL CARE DHMO

1. Go to cigna.com and click on "Provider Directory" to locate in-network dentists.
2. Note the six-digit dental office number from your dentist's record on this site, this number is required during enrollment. Whether or not you have the same primary care dentist, you'll need to enter a dental office number for each enrolled dependent.
3. Make an appointment with the dentist listed on your card. To change your dentist, you first must:
   - Verify that the new dentist is in the DHMO network and is accepting new patients.
   - Contact CIGNA to make the company aware of the change.
4. Verify that your ID card has the correct provider information before you receive services.
5. Present your card to the dentist at the time of service.

DELTA PREFERRED PPO

1. You can locate in-network providers by calling Delta Dental at (800) 524-0149, or going to deltadentalin.com. Search in the DeltaPreferred network to find participating dentists.
2. Make an appointment with the dentist of your choice.
3. Inform the dentist that you are a DeltaPreferred participant.
4. Make sure that your dentist uses your correct Social Security number to verify eligibility and for you and/or your spouse or dependents. Your coverage levels are based on whether or not your dentist is a PPO dentist.
5. If you see a dentist who is not contracted with either the DeltaPreferred PPO or DeltaPreferred Passive PPO, you may have to file a claim form. You don't need to designate a primary care dentist; you can refer yourself to a specialist.

DELTA PREFERRED PASSIVE PPO

1. Follow steps 1 and 2 in the DeltaPreferred PPO instructions.
2. Inform the dentist that you are a DeltaPreferred participant.
3. Your coverage levels are the same no matter what licensed dentist you see, but with DeltaPreferred contracted dentists, you will not be billed for any amount that exceeds Delta's UCR limits in your area and you will receive discounted fees. You may be required to file a claim form. If you see a dentist who is not contracted with DeltaPreferred, you are responsible for paying any claim amount that exceeds Delta's UCR limit and you'll have to file your own claim form. You don't need to designate a primary care dentist an you can refer yourself to a specialist.

Make sure your dentist uses your correct Social Security number to verify eligibility and benefits for you and/or your spouse or dependents. Your coverage levels are based on whether or not your dentist is contracted with DeltaPreferred.

Vision Service Plan (VSP)

VSP's program provides affordable, quality vision care nationwide. Through VSP's provider network, you'll receive a comprehensive vision examination as well as materials, if needed.

Vision plan features	VSP benefit coverage
Network coverage	VSP Choice network
Examination (once every calendar year)	In-network: Covered in full after $10 copay Out-of-network: Exa, up to $45
Lenses or medically necessary contact lenses (once every calendar year)	In-network: Covered in full after $10 copay Out-of-network: Up to $100, depending on lens type
Frames (once every other calendar year)	In-network: Covered in full up to $50 wholesale retail chain: $130 allowance Out-of-network: Up to $70
Disposable and nondisposable contact lenses Once every calendar year	In-network: Covered up to $120 retail value Out-of-network: Up to $105
Semimonthly vision rates Associate Associate + child(ren) Associate + spouse Family	 $ 2.98 $ 6.39 $ 5.97 $ 10.20

How do I use the VSP vision plan?

1. Find the right VSP Choice Plan doctor for you at vsp.com or call VSP at (800) 877-7195.
2. Call your doctor to make an appointment.
3. When you call, tell the doctor you are covered by the VSP Choice Plan.
4. After you make an appointment, your doctor's office and VSP will handle the rest.
5. If you see an out-of-network provider, VSP will reimburse you up to the amount allowed under the plan's out-of-network provider reimbursement allowance. Be aware that your out-of-network reimbursement allowance does not guarantee full payment. You must file the claim for out-of-network services within six months of seeing the provider. If you are eligible for services from a non-VSP provider, you will be required to pay the provider in full at the time of service.

To ensure a timely reimbursement, send the following information to VSP:

- An itemized receipt listing the services you received
- The name, address and phone number of the non-VSP provider
- The covered member's I.D. number
- The covered member's name, phone number and address
- The name of the organization that provides your VSP coverage
- The patient's name, date of birth, phone number and address
- The patient's relationship to the covered member (such as "self," "spouse," "child")

Please keep a copy of the information and mail the originals to:

VSP
Attn: Out-of-Network Claims
P.O. Box 997105
Sacramento, CA 95899-7105

Stay protected with term life and accidental death and dismemberment (AD&D) insurance

Company-paid term life and AD&D insurance

Company-paid term life insurance is provided to you in the amount of one times your salary up to a maximum of $400,000. No Evidence of Insurability (EOI) is required for this basic coverage.

You'll also receive company-paid AD&D insurance coverage equal to one times your salary up to a maximum of $400,000. AD&D coverage pays the insured a benefit if he or she is dismembered in an accident. The beneficiary is paid if the insured dies as a result of an accident. AD&D benefits are paid in addition to life insurance benefits in the case of accidental death. Sun Life Financial is the administrator for term life insurance and AD&D benefits.

Supplemental life insurance and AD&D coverage

- You may elect to purchase additional life and AD&D insurance coverage for yourself and your spouse, and term-life-only coverage for your child(ren). Unless you're enrolling within the first 30 days of becoming eligible, you and your dependents are required to provide EOI to receive coverage. Approval of your elected amount is contingent upon review and approval by Sun Life Financial.
- During Annual Enrollment, you and/or your spouse may increase current coverage by one option level [up to the Guaranteed Issue (GI) amounts] without EOI.
- For new hires who enroll when they are first eligible, the EOI requirement is waived up to the GI amount of $500,000 for associates, $50,000 for spouses and $10,000 for child(ren).
- Anyone who is not a new hire, or did not chose to enroll during the previous Annual Enrollment period, must provide EOI for any amount elected.
- The AD&D benefit is paid only if death occurs within 365 days after the injury. If a person is in a coma for 11 months after the accident, the beneficiary may receive a benefit up to 5% of the AD&D benefit. If the person is in a coma for 12 months, the full AD&D benefit is available, minus any amount already paid.
- **When you or your spouse reach a new supplemental life rate bracket, a premium increase will be calculated.** The adjusted premium deduction will take effect on your first paycheck following that birthday.
- The combination of company-paid life insurance and any additional supplemental life insurance you elect can't exceed $500,000 without EOI.

Associate supplemental life insurance and AD&D coverage

You may choose one of the options listed below for supplemental life and AD&D insurance for yourself. The cost per $1,000 of coverage depends on your age. Face amounts in excess of the GI amounts of $500,000 will require EOI. You need to access Benefits InfoNet to obtain the forms and instructions for completing the EOI process for yourself and/or your spouse. Amounts that exceed the GI limit are not loaded to the HR system until approval is received from Sun Life Financial. The combined maximum of company-paid term life and supplemental life insurance for an associate is $900,000.

Face amount	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10
	$10,000	$25,000	$50,000	$100,000	$200,000	$300,000	$400,000	$500,000	$600,000	$700,000

Monthly rates per $1,000 of coverage	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
	.049	.060	.075	.104	.169	.266	.463	.491	.579	.676	.755	.966

Example: You're 46 years old and want $200,000 worth of life insurance.
Multiply .169 x 200 = $33.80, which is your monthly premium.

Spousal life insurance and AD&D coverage

You may purchase life and AD&D coverage for your spouse if you also purchase supplemental associate life insurance for yourself. The amount of spousal insurance cannot be more than half the amount of your coverage. Spousal face amounts in excess of $50,000 require EOI. The available options and cost of spousal coverage are listed in the tables below.

Face amount	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
	$5,000	$12,500	$25,000	$50,000	$100,000	$150,000	$200,000	$250,000

Monthly rates per $1,000 of coverage	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
	.062	.074	.089	.117	.181	.280	.478	.504	.593	.690	.769	.980

Child(ren) coverage (does not include AD&D)

You may elect term life insurance coverage for your dependent children in the amount of $10,000 per child. This covers children from birth through age 18 or up to age 26 if your child depends on you for 50% or more of his/her support. One policy covers all of your eligible dependent children. The total cost for this coverage is $2.00 per month, regardless of the number of children covered. You must purchase supplemental associate life insurance to be eligible to purchase child life insurance. No EOI is required for child life insurance.

How do I name a beneficiary?

You'll be asked to designate one or more beneficiaries for your life insurance only. Your beneficiaries are the individuals who will receive your group life and AD&D insurance benefits in the event of your death. You may change your beneficiaries at any time by logging on to HR*connect*. Go to the Benefits Enrollment tab and click "Manage Beneficiaries" make changes. If you have not named a beneficiary at the time of your death, benefits will be paid to your:

- Spouse, if any, then
- Children in equal shares, then
- Parents, then
- Brothers and sisters, then
- Estate

For spousal and child insurance, you (the associate) are always the beneficiary.

How can I port my life insurance coverage to an individual policy?

The portability provision allows you to continue coverage on a group rate basis, subject to certain limits and at your own expense, if you apply within 10 days of the date your coverage ends. AD&D coverage is not portable. Portability also applies to your spouse and children. To request portability, log in to Benefits InfoNet to access the "Portability Notice" form.

	Face amount	Eligibility ages
Employee	$5,000–$500,000	Up to age 69
Spouse	$1,000–$25,000	Up to employee age 69
Children	$1,000–$5,000	Through age 18, or 22 if full-time student

How can I convert my life insurance coverage to an individual whole life policy?

Subject to the terms of the group policy, you can apply for an individual insurance policy in conversion of your group term life. A medical exam is not required, but application and payment of the first premium must be made within 31 days of the date your group term insurance terminates. To request conversion to a whole life policy, log in to Benefits InfoNet to access the "Conversion Notice" form.

How do I submit a life insurance claim?

Submit a certified copy of the death certificate or proof of AD&D loss to:

CNO HR Service Center
P.O. Box 10407
Des Moines, IA 50306-3515

Claims for dismemberment loss must be filed within 12 months of the injury date. Benefits are paid as soon as possible after the insurance provider receives proof of death or AD&D loss.

Business travel accident insurance

Business travel accident insurance pays benefits if you're seriously injured or killed in a covered accident while traveling on business for CNO. This company-paid benefit is available to all regular associates who are scheduled to work a minimum of 20 hours per week. Eligibility begins on the first of the month following one full calendar month of employment.

The benefit per associate is $200,000.

Protect your income with long-term disability insurance

LTD insurance provides supplemental income if you become disabled due to a covered injury or sickness. Long-Term Disability coverage is issued by CIGNA.

LTD insurance—company-paid

A company-paid LTD benefit is provided to you at the 40% level. This means that if you become disabled and LTD is approved, the company will provide a benefit equal to 40% of your lost monthly earnings (minus taxes).

LTD insurance—associate-paid "buy-up" option

In addition to the company-paid option, you may purchase a 20% buy-up LTD benefit that increases your total LTD benefit to 60% of your lost monthly earnings. If you elect the buy-up option on or after January 1, 2013, and you weren't enrolled in the 60% LTD benefit for 2012, you'll need to complete an EOI form and be approved for this level of coverage for 2013.

Taxes are deducted from the company-paid portion of the benefit if you qualify for LTD benefits in the future. The 20% buy-up option is an after-tax benefit, so taxes are deducted from the premiums you pay now and therefore won't be deducted from this portion of any LTD benefits you receive.

General information

LTD benefits begin 90 days after your date of disability. **(Note: Company-provided short-term disability benefits are offered but are separate from this benefit.)** During the first 24 months, disability is determined based on a definition relating to your regular occupation.

To qualify for benefits:

- During the first 24 months of disability, your disability must be an injury, sickness or pregnancy that requires you to be under the regular care of a doctor and that prevents you from performing the material and substantial duties of your regular occupation.
- After 24 months of disability, your disability must be an injury or sickness that requires you to be under the regular care of a doctor and prevents you from performing the material and substantial duties of any gainful occupation for which you are qualified by education, training and experience.

What is the amount of my LTD benefit?

If you become disabled, you will receive a benefit of 40% or 60% of your monthly covered earnings, depending on your election. Company-paid LTD coverage is subject to a monthly maximum benefit of $7,500 if you are disabled. (The annual salary to reach the maximum benefit of $7,500 is $225,000 or more at the 40% level.) Buy-up LTD coverage is subject to a monthly maximum of $15,000 if you elect this coverage and are disabled. (The annual salary to reach the maximum benefit of $15,000 is $300,000 at the 60% level). LTD benefits continue until the date one of the following events occurs:

- You're no longer disabled.
- You're earning more than the amount allowed under the plan.
- You fail to submit proof of your disability.
- You're able to return to work part-time and you refuse to do so.
- You refuse to participate in rehabilitation services.
- You reach the maximum benefit period.
- You pass away.

LTD rate example

The monthly rate for the additional 20% buy-up LTD coverage is:

Additional coverage	Monthly rate
20% level	$0.0020 of covered earnings

Covered earnings are defined as your annual base salary excluding bonuses, commissions, overtime pay and other compensation.

To calculate your monthly premium for the additional 20% benefit, assume that your covered earnings equal $40,000. Divide that amount by 12 months and multiply by $0.0020. In this example, your monthly rate for the additional 20% benefit level would be $6.67 per month.

What is the maximum benefit period for LTD insurance?

The later of the associate's SSNRA* or the Maximum Benefit Period as listed below:

Your age on the date disability begins	Maximum benefit period
Age 62 or younger	To your 65th birthday or 42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months

For mental illness limitations, please see the "Long-Term Disability Group Disability Insurance Certificate" at Benefits InfoNet.

How can other disability coverage affect my LTD benefits?

Any disability payments you receive from a source of deductible income under the LTD plan may offset the LTD benefits you receive under this LTD plan. Your LTD benefit may also be reduced by any salary you earn.

When will my LTD benefits end?

Your coverage ends on the soonest of the following:

- The date you become eligible for a plan of benefits intended to replace this coverage.
- The date your employment terminates or you become ineligible.
- The date the plan ends.
- The date you fail to pay a required premium.
- The date of your death.

What will happen with my LTD benefits when I return to work from a covered disability?

If you become disabled, return to work, but then become disabled again, your disability benefits will resume without an elimination period if the second disability begins within six months of your return to work and if the disability results from the same cause or a related one.

If you return to work for a longer period than indicated above before the same disability returns, you'll receive benefits after a new elimination period. If you return to work and then are disabled for a different cause, you'll need to satisfy a new elimination period before benefits begin.

During the first 12 months of payments, if you're still working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payments do not exceed 100% of indexed monthly earnings.

When are LTD benefits not payable?

LTD benefits are not paid for disabilities resulting from:

- War or any act of war (declared or undeclared.)
- Intentionally self-inflicted injury.
- Active participation in a riot.
- Commission of a crime for which you are convicted under state or federal law.
- The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless you are disabled under the terms of the plan.
- A pre-existing condition.

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 1 and 2 are true:

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

A standard 24-month benefit limit applies for disabilities due to mental illness.

How can I convert my LTD coverage to an individual policy?

Subject to the terms of the group policy, you may be eligible to convert LTD insurance to Disability Conversion Insurance (DCI) if your active coverage terminates. To enroll for DCI coverage without establishing medical or other EOI, you must submit a completed enrollment form within 60 days of your termination date. To request conversion to an individual policy, go to Benefits InfoNet to access the CIGNA LTD Conversion Form.

* SSNRA is the Social Security Normal Retirement Age in effect under the Social Security Normal Retirement Act on the Plan Effective Date.

Manage life's challenges with the Employee Assistance Program (EAP)

The EAP is a service designed to help you manage life's challenges. Through the EAP, a professional counselor can help you or your eligible family members assess personal problems that may affect your health, family life, abilities and desire to excel at work. You and your eligible family members are entitled to up to six complimentary sessions per individual, per incident, per calendar year. Longer-term treatment referrals can be made as necessary. The EAP also provides telephone counseling for a broad range of issues, including:

- Marital, family and other relationship problems
- Alcohol or drug dependence
- Depression, stress and emotional problems
- Financial or legal difficulties
- Child- and elder-care assistance
- Retirement planning
- Federal tax consultation

You can access EAP information and tools at members.mhn.com. Register on this site with the access code, "cno." With a few clicks you can:

- Search for an counselor and get a referral
- Manage your stress with interactive tools
- Take a health risk assessment
- Ask an expert questions about emotional health

How do I use EAP benefits?

EAP sessions are prepaid and confidential counseling is provided by Managed Health Network (MHN). For assistance or to schedule an appointment, call (800) 977-7637 24 hours a day, 7 days a week. Any contact you have with the EAP is kept completely confidential.

Who is eligible to use EAP benefits?

All associates are automatically enrolled in the EAP on the first day of the month following one calendar month of employment. There's no enrollment form to complete. CNO pays the enrollment fees.

Your EAP access ends on the last day of the month in which your employment terminates, unless you elect COBRA continuation coverage.

Are my dependents covered under the EAP?

If your spouse or same-sex domestic partner and children are eligible to participate in the medical plan, they are automatically enrolled in the EAP.

Your Spending Accounts

Stretch your health and dependent care dollars with Flexible Spending Accounts (FSAs)

Health care and dependent care FSAs let you set aside pre-tax money that you anticipate spending for certain healthcare or child/dependent care expenses. After you incur eligible expenses and submit appropriate receipts with your completed claim form, you'll be reimbursed with tax-free dollars from your account. WageWorks is the administrator of our FSA plan. Go to wageworks.com for a complete list of eligible expenses for 2013.

Participation in health care and dependent care FSAs stops at the end of each plan year (December 31). You must re-enroll each year during the Annual Enrollment period to have FSA benefits for the next plan year.

Per the Patient Protection and Affordable Care Act, the 2013 maximum contribution to a health care FSA is $2,500.

Remember: Participation in CNO's general purpose health care FSA is restricted. Participation in the health care FSA is only available to associates who are not enrolled in a medical option under the CNO Care Options Plan or who are not eligible for an HSA. Refer to the HSA qualifications on page 9.

HOW MUCH CAN I CONTRIBUTE?

Health care FSA	Dependent care FSA
Minimum: $120 per year	**Minimum:** $120 per year
Maximum: $2,500 per year	**Maximum:** $5,000 per year

Note: On your federal income-tax return, if you are single or married filing jointly, you may contribute up to $5,000 per year to your dependent care FSA. If you are married and filing separately, you and your spouse may each contribute $2,500 per year.

HEALTH CARE FSA

Through the health care FSA, you will be reimbursed for certain healthcare expenses.

IMPORTANT TO NOTE: If you are a participant in CNO's medical plan and contribute to an HSA, your health claims cannot be eligible for reimbursement under any "general purpose" health care FSA (including your spouse's FSA.) This means that if your spouse has a general purpose health care FSA, you are not eligible to contribute to an HSA.

HEALTH CARE FSA CONTRIBUTION EXAMPLE

Suppose you and your family expect to experience the following medical services in 2013:

Expense	You	Other dependents	Out-of-pocket amount
Expected office visits (co-insurance and member responsibility)	2	2	$200
Rx, non preferred brand	1 per month	1 per month	$530
Braces for dependent child		1	$1,400 after insurance
Eyeglasses	1	1	$270
Total out-of-pocket expenses for year			$2,400

Based on this example and an estimated level of out-of-pocket expenses for this year, you would want to enroll in a health care FSA with a monthly contribution level between $180 and $200.

This example is based on 2012 tax rates. The effect on your current taxes will depend on your own income, tax status, applicable tax rates for the year of your FSA contribution and your FSA contribution level. Specific savings must be individually determined. This example assumes you're married filing jointly and does not include state and/or local taxes.

	Not using the FSA	Using the FSA
Taxable income before FSA	$60,000	$60,000
— FSA contribution	**$ 0**	**$ 2,400**
Taxable income	$60,000	$57,600
— Federal income and Social Security taxes	**$11,556**	**$11,060**
Take-home pay	$48,444	$46,540
— After-tax health or dependent care expenses	**$ 2,400**	**$ 0**
Spendable pay	$46,044	$46,540
TAX SAVINGS		**$ 496***

*By law, we may not offer tax or legal advice. These materials are written for general and informational purposes only. Based upon individuals' particular circumstances and objectives, they should seek specific advice from their own qualified and duly-licensed independent tax or legal advisers. No one may rely upon or use the information here for the purposes of avoiding any tax or tax penalty that may be imposed by the Internal Revenue Code or other applicable law.

The amount you contribute to your health care FSA is not subject to federal, state or Social Security (FICA) taxes, which can translate to a savings of 15% to 40% depending on your tax bracket. This personal tax savings helps reduce the cost of required expenses and can increase your spendable income. Expenses that are not covered include health club membership fees, insurance premiums, nutritional supplements, cosmetic services or supplies, and others.

What is the health care card, and how do I use it?

The healthcare card is an easy way to access your health care FSA. It is a prepaid card that can be used at many merchants who sell healthcare products or services and accept Visa® or MasterCard® debit cards. To use this card, choose the credit option because it has no PIN. You can use it at the point of service to pay for deductibles, coinsurance amounts and more. When you use the healthcare card, funds are immediately transferred from your FSA to the provider. You don't have to pay the money upfront, but you must keep all receipts, as you will likely be asked to submit them for auditing purposes.

You'll receive a healthcare card automatically when you enroll for the first time in the health care FSA. (You'll continue to use the same card each year thereafter you are enrolled.) It's easy to use the card for valid purchases, but it can't be used for nonreimbursable items. More details will be provided with the card once you enroll in a health care FSA.

How can I file a paper claim with WageWorks?

If you do not use your healthcare card, you can file a claim for eligible expenses incurred while you are a participant in the health care FSA program during the covered plan year. When you file a healthcare claim larger than the funds currently in your account, you'll be reimbursed for the full claim amount (up to your total annual contribution) as long as the claim is incurred during your covered plan year. The reimbursement claim form is available at wageworks.com.

What's the deadline to submit all claims?

You have until March 31, 2014, to submit claims for expenses incurred between January 1, 2013, and December 31, 2013. Claims received after this date will not be considered for reimbursement, and any remaining FSA balance will be forfeited. Also, if you terminate employment during the year, monies in your account at termination will be forfeited unless you (1) submit valid receipts for services that occurred before that date or (2) elect to continue the health care FSA benefit through COBRA continuation until the end of the year and submit receipts for valid services rendered.

Dependent care FSA

Through the dependent care FSA, you'll be reimbursed for work-related dependent care expenses (child- or elder-care) on a tax-free basis. To be eligible, expenses must be necessary so you and your spouse (if you are married) can work, actively look for work or attend classes as a full-time student.

While most people think of dependents as children, dependents can be other family members who are physically or mentally unable to care for themselves (such as a parent living with you). Dependent children are covered until their 13th birthday.

Expenses that qualify for reimbursement include:

- Care provided in your home, in another person's home or in a licensed daycare center, as long as you do not claim the caregiver as a dependent on your federal income-tax return. (If the facility provides care for more than six individuals, it must meet state and local licensing requirements.)
- Services provided outside your home for a dependent who regularly spends at least eight hours a day in your home.

Expenses for a child in nursery school, preschool or a similar program for children below kindergarten level are reimbursable.

Expenses to attend kindergarten or a higher grade are not reimbursable, but expenses for before- and after-school care for a child in kindergarten or a higher grade are reimbursable.

Dependent care tax facts

Depending on your personal tax situation, you need to decide whether it is more beneficial for you to use the dependent care FSA or claim the dependent care tax credit on your federal income-tax form. Many individuals receive a greater benefit with the dependent care FSA, but it's always a good idea to check with your tax advisor.

How do I use a dependent care FSA?

Dependent care claims are paid only up to the amount withheld year-to-date from your paycheck. Any portion of your claim that was not reimbursed is marked "pending" and will be paid at a later date, after more funds are withheld from your paycheck and credited to your FSA. The reimbursement claim form is available on wageworks.com.

You have until March 31, 2014, to submit claims for services incurred from January 1, 2013, through December 31, 2013. Claims received after this date will not be considered for reimbursement, and any remaining balance will be forfeited. Also, if you terminate employment during the year, monies in your account at termination will be forfeited unless you submit valid receipts for services that occurred before that date. Dependent care FSA benefits may not be continued through COBRA.

WHAT ELSE SHOULD I CONSIDER BEFORE ENROLLING IN FSA?

The Internal Revenue Code imposes certain restrictions on FSAs:

- Any money remaining in your FSA after December 31, 2013, will be forfeited. (Note: During a three-month period—through March 31, 2014—you may submit claims dated December 31, 2013, or earlier.) You can avoid forfeitures by carefully reviewing last year's expenses, reviewing your benefit choices for 2013, estimating costs for 2013 based on those benefit choices and committing to a little less. Unless you experience a change in employment or family status, you are bound to these contributions for an entire year.
- Amounts are held in separate health and dependent care accounts, and balances can't be moved back and forth.
- The dependent care FSA must be used for work-related dependent care expenses. **It may not be used to reimburse medical expenses for your dependents.**

Gain added protection with Washington National and Bankers life supplemental products

WASHINGTON NATIONAL CRITICAL SOLUTIONS®

CANCER, HEART/STROKE AND RENAL FAILURE SUPPLEMENTAL INSURANCE

Did you know?

- Men have nearly a 1-in-2 lifetime risk of developing cancer. Women have a 1-in-3 lifetime risk.[1]
- Each year an estimated 785,000 Americans will have a new heart attack.[2]
- On average, every 40 seconds in U.S. someone has a stroke.[2]

[1]American Cancer Society, Cancer Facts & Figures 2011, p. 1.
[2]American Heart Association, Heart Disease and Stroke Statistics—2011 Update, p. 19.

The above statistics represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the policy by the sources cited above.

Why do I need critical illness insurance?

Day-to-day life is complicated enough all on its own. So when you're facing the extra stress of a critical illness, you need to keep your financial worries to a minimum. You need the assurance of a supplemental health insurance policy that helps protect your family, finances and future.

Medical plans are designed to help pay your direct medical expenses, including doctor bills, hospital bills and medications. But many indirect costs related to critical illness treatments are not typically covered by health insurance. These indirect, out-of-pocket costs can include insurance copayments and deductibles, lost wages, special foods, childcare expenses and counseling.

Washington National Critical Solutions can provide benefits to help with the direct and indirect expenses of a critical illness diagnosis and treatment.

General features

- **Direct payments.** Payments go directly to you or whomever you choose unless otherwise required. The benefits are paid regardless of any other type of insurance coverage you have.
- **Customization.** With three coverage types and two plan options, you can customize a plan to meet your needs and budget.
- **Lifetime renewability.** Your policy is guaranteed renewable for life. It cannot be canceled because of your age or health. Your benefits are not reduced at any age.
- **Premium return.** Your premiums are returned to you, minus claims, within the specified period of time outlined in the rider.
- **Stable rates.** Your premium cannot be increased if you remove your insurance coverage from payroll deduction. You cannot be singled out for a rate increase. Your rates can be changed only if rates are changed on all policies/certificates of this type in your state.

Washington National Critical Solutions benefits[3]

- Lump-sum benefit up to $70,000
- Wellness benefit
- Hospital confinement
- Consultation benefit
- Radiation and chemotherapy treatments

Optional rider[4]

- Return of Premium

Rates and coverage. Coverage levels and rates may vary by state. Premiums are based upon the level of coverage selected. You must meet applicable criteria for insurability to be eligible for insurance provided by Washington National.

For more information. Go to the enrollment website and indicate your interest on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 541-2254.

[3]Depending upon your plan selection, some benefits may have an additional cost. For complete details of coverage, including state availability of products and benefits, highlight "yes" on the Washington National products screen during online enrollment. The benefits of this policy are described in policy form series CIC1039 and state variations, where applicable.

[4]This rider has an additional cost.

A hospital is not a bed, unit or facility that functions as a skilled nursing facility, nursing home, extended care facility, convalescent home, rest home, home for the aged, sanatorium, rehabilitation center, place primarily for providing care for alcoholics or drug addicts or facility for the care and treatment of mental diseases or mental disorders. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Washington National Critical Solutions is issued by Washington National Insurance Company (home office: Carmel, Indiana).

WASHINGTON NATIONAL WORKSITE CRITICAL ILLNESS®

GROUP CRITICAL ILLNESS SUPPLEMENTAL INSURANCE

Consider the facts

- 1-in-2 men and 1-in-3 women are at risk of developing some form of cancer in their lifetime.[1]
- About 81.1 million Americans have cardiovascular disease.[2]
- On About half of all personal bankruptcies are attributed in part to medical problems.[3]

[1]American Cancer Society, Cancer Facts & Figures 2012, p. 1.

[2]American Heart Association/American Stroke Association, Heart Disease and Stroke Statistics—2010 Update At-A-Glance, 2010, pg. 2.

[3]"Top 5 Reasons Why People Go Bankrupt," Investopedia, March 22, 2010.

The above statistics represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the policy by the sources cited above.

Why do I need critical illness insurance?

Each year millions of Americans are diagnosed with critical illnesses. The good news is that more people are surviving such a diagnosis. Still, some of the costs associated with treatment are not paid by major medical insurance and must be paid out of your own pocket. That's where supplemental insurance can help.

Washington National Worksite Critical Illness offers benefits in three health diagnosis categories (HDCs):

- HDC 1: Heart attack, stroke, heart transplant as a result of heart failure, and coronary artery bypass surgery
- HDC 2: Major organ transplant (other than heart), end-stage renal failure and blindness
- HDC 3: Cancer

General features

- **Direct payments.** Payments go directly to you or whomever you choose unless otherwise required. The benefits are paid regardless of any other type of insurance coverage you have.
- **Customization.** With three coverage options, you can customize a plan to meet your needs and budget.
- **Premium return.** Your premiums are returned to you, minus claims, within the specified period of time outlined in the rider.
- **Stable rates.** Your premium cannot be increased if you remove your insurance coverage from payroll deduction. You cannot be singled out for a rate increase. Your rates can be changed only if rates are changed on all policies/certificates of this type in your state.

Washington National Worksite Critical Illness benefits[4]

- Lump-sum benefit from $5,000 to $75,000 (in 5,000 increments)
- Recurrence benefit
- Wellness benefit
- Spousal and child benefit

Optional rider[5]

- Return of Premium

Rates and coverage. Coverage levels and rates may vary by state. Premiums are based upon the level of coverage selected. You must meet applicable criteria for insurability to be eligible for insurance provided by Washington National.

For more information. Go to the enrollment website and indicate your interest on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 541-2254.

[4]Depending upon your plan selection, some benefits may have an additional cost.

[5]This rider has an additional cost.

For complete details of coverage, including state availability of products and benefits, highlight "yes" on the Washington National products screen during online enrollment. The benefits of this policy are described in policy form series CIC1034 and state variations, where applicable. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Washington National Worksite Critical Illness is issued by Washington National Insurance Company (home office: Carmel, Indiana).

WASHINGTON NATIONAL SOLUTIONS® CANCER

INDEMNIFIED CANCER SUPPLEMENTAL INSURANCE

Did you know?

- Women have more than a 1-in-3 lifetime risk of developing cancer; men have a 1-in-2 lifetime risk.
- About 11.7 million Americans alive today have a history of cancer.

Source: American Cancer Society, Cancer Facts & Figures 2011, p. 1.

The above statistics represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the policy by the American Cancer Society.

Why do I need cancer insurance?

Medical plans are designed to help pay your direct medical expenses, including doctor bills, hospital bills and medications. But many indirect costs related to cancer treatment are not typically covered by health insurance. These indirect or out-of-pocket costs can include insurance copayments and deductibles, lost wages, special foods, childcare expenses and counseling. Transportation, food and lodging expenses associated with out-of-town treatments can add up as well.

Washington National Solutions Cancer is designed to help you deal financially with the indirect costs of a cancer diagnosis. It pays benefits directly to you or someone you designate.

General features

- **Direct payments.** Payments go directly to you or whomever you choose unless otherwise required. The benefits are paid regardless of any other type of insurance coverage you have.
- **Lifetime renewability.** Your policy is guaranteed renewable for life. It cannot be canceled because of your age or health. Your cancer benefits are not reduced at any age.
- **No lifetime maximum.** There's no lifetime maximum on any benefit unless noted in the policy.
- **Premium return.** Your premiums are returned to you, minus claims, within the specified period of time outlined in the rider.
- **Stable rates.** Your premium cannot be increased if you remove your insurance coverage from payroll deduction. You cannot be singled out for a rate increase. Your rates can be changed only if rates are changed on all policies/certificates of this type in your state.

Washington National Solutions Cancer benefits[1]

- First-occurrence express payment
- Radiation and chemotherapy treatments
- Blood and plasma
- Daily hospital confinement
- Skilled nursing facility and hospice care
- Ambulance
- Wellness benefit
- Leukemia bone marrow transplant
- Stem cell transplant
- Transportation and lodging
- Wigs and hairpieces
- Surgery and anesthesia
- Home healthcare

Optional riders[2]

- Hospital Intensive Care
- Alternative Care
- Return of Premium

Rates and coverage. Coverage levels and rates may vary by state. Premiums are based on the level of coverage selected. You must meet applicable criteria for insurability to be eligible for insurance provided by Washington National.

For more information. Go to the enrollment website and indicate your interest on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 541-2254.

[1]This is a partial list of benefits. For complete details of coverage, including state availability of products and benefits, highlight "yes" on the Washington National products screen during online enrollment. The benefits of this policy are described in policy form series CHIC-5022C and state variations, where applicable.

[2]These riders have an additional cost. Hospital Intensive Care rider is not available in Indiana.

This insurance is available only to members of Health Opportunity through Partnership in Education (HOPE). A hospital is not a bed, unit or facility that functions as a skilled nursing facility, nursing home, extended care facility, convalescent home, rest home, home for the aged, sanatorium, rehabilitation center, place primarily for providing care for alcoholics or drug addicts or facility for the care and treatment of mental diseases or mental disorders. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Washington National Solutions Cancer is issued by Washington National Insurance Company (home office: Carmel, Indiana).

PULSE PROTECTION SERIES℠

INDEMNIFIED HEART/STROKE SUPPLEMENTAL INSURANCE

Did you know?

- More than 1.5 million Americans experience a new coronary attack or new stroke each year.
- Someone in the U.S. suffers a stroke every 40 seconds.
- In a single year, the cost of cardiovascular disease and stroke is estimated at more than $286 billion—more than any other diagnostic group.

Source: American Heart Association, Heart Disease and Stroke Statistics—2011 Update, p. e19, e20.

The above statistics represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the policy by the American Heart Association.

Why do I need insurance against heart disease, heart attack and stroke?

Your major medical insurance is designed to pay doctor and hospital bills. But a number of expenses are not covered by major medical. Out-of-pocket costs can include insurance deductibles and copayments, transportation and lodging for out-of-town medical treatment, lost wages and special diets. If you experience heart disease, heart attack or stroke, the Pulse Protection Series from Washington National can pay benefits when you need them most.

General features

- **Direct payments.** Payments go directly to you or whomever you choose unless otherwise required. The insurance benefits are paid regardless of any other type of insurance coverage you have.
- **Lifetime renewability.** Your policy is guaranteed renewable for life. It cannot be canceled because of your age or health. The disability benefit is renewable to age 70.
- **No lifetime maximum.** There's no lifetime maximum on any benefit except as noted in the policy.
- **Premium return.** Your premiums are returned to you, minus claims, within the specified period of time outlined in the rider.
- **Stable rates.** Your premium cannot be increased if you remove your insurance coverage from payroll deduction. You cannot be singled out for a rate increase. Your rates can be changed only if rates are changed on all policies/certificates of this type in your state.

Pulse Protection Series benefits[1]

- Daily hospital confinement
- Attending physician and private nurse
- Surgery and anesthesia
- Ambulance
- Blood and plasma
- Transportation and lodging
- Electrocardiogram
- Heart transplant

Optional riders[2]

- Return of Premium

Rates and coverage. Coverage levels and rates may vary by state. Premiums are based on the level of coverage selected. You must meet applicable criteria for insurability to be eligible for insurance provided by Washington National.

For more information. Go to the enrollment website and indicate your interest on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 541-2254.

[1] This is a partial list of benefits. For complete details of coverage, including state availability of products and benefits, highlight "yes" on the Washington National products screen during online enrollment. The benefits of this policy are described in policy form series KH000/PS1ST and state variations, where applicable.

[2] Optional riders have an additional cost. The Return of Premium is not available in Pennsylvania.

A hospital is not a bed, unit or facility that functions as a skilled nursing facility, nursing home, extended care facility, convalescent home, rest home, home for the aged, sanatorium, rehabilitation center, place primarily for providing care for alcoholics or drug addicts or facility for the care and treatment of mental diseases or mental disorders. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Pulse Protection Series is issued by Washington National Insurance Company (home office: Carmel, Indiana).

ACCIDENT ASSURE®

ACCIDENTAL INJURY & DISABILITY INCOME SUPPLEMENTAL INSURANCE

Did you know?

- 66% of all accidents occur off the job.
- More than 34 million people in the U.S. receive medical attention for an injury every year.
- Every second of every day, someone is disabled from an accidental injury.

Source: National Safety Council, Injury Facts, 2010 Edition.

The above statistics represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the policy by the National Safety Council.

Why do I need accidental injury and disability insurance?

For an accidental injury or disability, your health insurance covers your medical expenses, such as doctor and hospital bills. And workers' compensation applies if you're injured on the job. But if you're accidentally injured or disabled, you may have to pay out of your own pocket for expenses like special transportation, home care and childcare. Loss of income can become your most costly expense, threatening your lifestyle. Disability income options pay from the first day of accident disability and from the 15th day for sickness disability.

General features

- **Direct payments.** Payments go directly to you or whomever you choose unless otherwise required. You decide how to spend the money.
- **Lifetime renewability.** Your insurance is guaranteed renewable for life. It cannot be canceled because of your age or health. The disability benefits and associated riders are renewable to age 70.
- **Premium return.** Your premiums are returned to you, minus claims, within the specified period of time outlined in the rider.
- **Stable rates.** Your premium cannot be increased if you remove your insurance coverage from payroll deduction. You cannot be singled out for a rate increase. Your rates can be changed only if rates are changed on all policies of this type in your state.

Accident Assure benefits[1]

- Accidental death and dismemberment benefits
- Specific injury benefits
- Hospital confinement and ICU confinement benefits
- Ambulance and emergency room benefits
- Transportation and family lodging benefits
- Physician's office visit benefits
- Off-the-job accident total disability or 24-hour accident short-term disability benefit options

Optional riders[2]

- Physician's Office Additional Benefit
- Sickness Disability
- Return of Premium
- Waiver of Premium

Rates and coverage. Coverage levels and rates may vary by state. Premiums are based on the level of coverage selected. You must meet applicable criteria for insurability to be eligible for insurance provided by Washington National.

For more information. Go to the enrollment website and indicate your interest on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 541-2254.

[1]This is a partial list of benefits. The off-the job accident total disability benefit is not available in Pennsylvania. For complete details of coverage, including state availability of products and benefits, highlight "yes" on the Washington National products screen during online enrollment. The benefits of this policy are described in policy form series CIC1022 and state variations, where applicable.

[2]These riders have an additional cost. Return of Premium is not available in Pennsylvania.

A hospital is not a bed, unit or facility that functions as a skilled nursing facility, nursing home, extended care facility, convalescent home, rest home, home for the aged, sanatorium, rehabilitation center, place primarily for providing care for alcoholics or drug addicts or facility for the care and treatment of mental diseases or mental disorders. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Accident Assure is issued by Washington National Insurance Company (home office: Carmel, Indiana).

HOSPITAL SECURE®

INDEMNIFIED HOSPITAL SUPPLEMENTAL INSURANCE

Why do I need hospital indemnity insurance?

A stay in the hospital can be expensive. But your first concern should be for care and treatment. Deductibles and copayments tied to medical events are rising. Even the most complete major medical coverage can leave you responsible for out-of-pocket expenses, like transportation and doctor office visits. A hospital indemnity plan is supplemental insurance for the expenses associated with a hospital stay.

Did you know?

- 1-in-6 Americans is hospitalized every year due to a sickness or accident.[1]
- The average hospital stay lasts four to five days.[1]
- Medical debt is the leading cause of half of all personal bankruptcies filed in the U.S.[2]

[1]"Voluntary Supplemental Medical and Hospital Indemnity Plans," Eastbridge Consulting Group, Inc., p. 15.

[2]"Medical Bankruptcy in the United States, 2007: Results of a National Study," American Journal of Medicine, Vol. 122, Issue 8, Aug. 2009, p. 741-746.

The above statistics represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the policy by the cited sources.

General features

- **Direct payments.** Payments go directly to you or whomever you choose unless otherwise required. You decide how to spend the money.
- **Guaranteed renewable to age 65.** Your insurance is guaranteed renewable to age 65. It cannot be canceled because of your health or claims status.
- **Stable rates.** Your premium cannot be increased if you remove your insurance coverage from payroll deduction. You cannot be singled out for a rate increase. Your rates can be changed only if rates are changed on all policies/certificates of this type in your state.

Hospital Secure benefit options[3]

- Hospital confinement benefit options up to $2,500
- Outpatient surgical benefit
- Doctor office visit benefit
- Emergency room benefit
- Daily hospital confinement benefit add-on

Optional riders[4]

- Hospitalization Daily Benefit rider
- Pet Boarding rider

[3]This is a partial list of benefits. Hospital Secure is not available in Pennsylvania. For complete details of coverage, including state availability of products and benefits, highlight "yes" on the Washington National products screen during online enrollment. The benefits of this policy are described in policy form series CIC1019 and state variations, where applicable.

[4]These riders have an additional cost.

Rates and coverage. Coverage levels and rates may vary by state. Premiums are based on the level of coverage selected. You must meet applicable criteria for insurability to be eligible for insurance provided by Washington National.

For more information. Go to the enrollment website and indicate your interest on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 541-2254.

A hospital is not a bed, unit or facility that functions as a skilled nursing facility, nursing home, extended care facility, convalescent home, rest home, home for the aged, sanatorium, rehabilitation center, place primarily for providing care for alcoholics or drug addicts or facility for the care and treatment of mental diseases or mental disorders. These policies have limitations and exclusions. For costs and complete details of coverage, contact your agent. Hospital Secure is issued by Washington National Insurance Company (home office: Carmel, Indiana).

WORKSITE UL2®

UNIVERSAL LIFE INSURANCE

Why do I need universal life insurance?

Buying life insurance through the workplace is one of the easiest ways to help protect yourself (the associate) and/or your spouse, children and even grandchildren. The Worksite UL2 policy offers associates and their family members life insurance and other benefits through a convenient signup process.

In addition to life insurance protection, you can choose additional benefits, such as annual automatic benefit increases and an accidental death benefit. Coverage is portable if you retire or otherwise leave the company.

Worksite UL2 riders

- Accidental Death Benefit*
- Accelerated Benefit for Terminal Illness*
- Automatic Benefit Increase*
- Children's Level Term Insurance*
- Waiver of Stipulated Premium*

Rates and coverage. The minimum coverage amount for a single life is $5,000 or the face amount provided by a target premium of $4 per week, whichever is higher. The maximum face amount is $150,000. The maximum death benefit can increase up to $250,000 with the Automatic Benefit Increase rider. The maximum face amount for child or grandchild policies is $42,500.

For more information. Go to the enrollment website and indicate your interest in this product on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll.

You also may contact a supplemental product specialist at (800) 628-6428 to request more information. Supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leave a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 525-7662.

Child coverage is available as a policy or with the child term rider, but not both. Grandchild coverage is not available in Pennsylvania.

*Riders are optional and may have an additional cost. The Accelerated Benefit for Terminal Illness is not available in Illinois and in Pennsylvania it is called "Accelerated Benefit for Limited Life Expectancy". The Waiver of Stipulated Premium is not available in Pennsylvania.

These policies have limitations and exclusions. Some benefits may not be available in all states. For costs and complete details of coverage, contact your agent. Worksite UL2 is issued by Washington National Insurance Company (home office: Carmel, Indiana).

WASHINGTON NATIONAL TERM LIFE PLUS®

TERM LIFE INSURANCE

Why do I need term life insurance?

Buying life insurance through the workplace is one of the fastest, most affordable ways to help protect yourself (the associate) and your family. Term life insurance is the simple, straightforward way to provide for loved ones in the event of death. Applying for coverage is easy, too.

Washington National Term Life Plus benefits[1]

- To-age-65 level-premium term offers coverage throughout your working years.
- A traditional 15-year level-premium term is also available.
- Critical Illness rider pays a lump-sum benefit to help with the costs of common critical illnesses.
- Built-in 50% return of premium benefit helps you get back some of your paid premiums.

Optional riders[2]

- Critical Illness rider
- Total and Permanent Disability Waiver of Benefits rider
- Accidental Death Benefit rider
- Children's Term Insurance rider
- Accelerated Benefits rider

Rates and coverage. Level-term premiums are unisex, issue-age rated and based on tobacco usage. The maximum death benefit is $250,000, the minimum is $10,000 or $4 per week, whichever is higher. Children are covered under a single premium rate at $10,000 each.

For more information. Go to the enrollment website and indicate your interest in this product on the Washington National products screen. At your request, a product specialist will contact you to answer questions, calculate rate information and help you enroll. You also may contact a supplemental product specialist at (800) 628-6428 to request more information. supplemental product specialists are available Monday through Thursday from 9 A.M. to 5 P.M. ET. If a specialist is not available when you call, you may leav a message and expect a return call within two business days. To cancel an in-force policy or one that has been applied for, contact Washington National customer service at (800) 525-7662.

Washington National Term Life Plus is not available in Pennsylvania. Child coverage is available only through the Children's Term Insurance rider.

[1]These policies have limitations and exclusions. Some benefits may not be available in all states. For costs and complete details of coverage, contact your agent. Washington National Term Life Plus is issued by Washington National Insurance Company (home office: Carmel, Indiana).

[2]Riders are optional and may have an additional cost.

BANKERS LIFE LONG-TERM CARE PRODUCTS

Three policies are available to meet your need for long-term care insurance:

1.Tax-qualified comprehensive long-term care

2.Tax-qualified home health care

3.Indiana long-term care insurance partnership policy1

What is long-term care?

Long-term care (LTC) is ongoing personal assistance when you need help caring for yourself due to a loss of physical or mental functioning as the result of an illness such as Alzheimer's disease. LTC may include help with activities of daily living, such as dressing, eating, bathing, toileting and transferring. Most people associate LTC with nursing homes, but care may be provided in a variety of locations, including your home or an assisted-living facility.

Why do I need LTC insurance?

Here are a few reasons why you may want to consider LTC insurance:

1. To protect your independence. If you should experience an illness that requires long-term care, health insurance and disability income does not pay for skilled nursing home care and home health care. A Long-Term Care policy can help you protect your assets from the high cost of needing long-term care. Long-Term care can be expensive depending on the type of care you need. Home health care averages $16,000 a year for a home health aide to assist you three times a week with household chores.[2]
2. Long-Term Care Insurance can help protect your family because the insurance provides benefits and features that can help your family take care of you and maintain your and their livelihood.

What are the benefits for associates?

In addition to the important protection that all Bankers Life LTC policies provide, our associate program offers these benefits:

1. A 5% discount off your total premium[3]
2. Premium payments through payroll deductions
3. Fully portable coverage
4. Flexible plan designs to meet your needs

How do I get more information?

Licensed Bankers Life agents will conduct a needs analysis with each associate and oversee the enrollment process to ensure you receive a LTC plan designed to meet your individual needs. To schedule an appointment with an agent, call (765) 289-2264 ext. 150.

[1]Available for Indiana residents only.

[2]National Clearinghouse for Long-Term Care Information, Understanding Long-Term Care, longtermcare.gov, 2007.

[3]Excluding home health care.

Contact Information

Human Resources Service Center (888) 477-2123

The Human Resources Service Center is open to all CNO associates Monday through Friday, 8 A.M. to 6 P.M., ET.
Use the numbers below when you have questions related to benefits, HR or payroll.

Provider/product	Phone	Website
MEDICAL (CNO Care Options Plan) CIGNA	(800) 244-6224	cigna.com
WELLNESS (OurClinics@CNO Plan) OurHealth	(866) 434-3255	https://portal.ourhealth.org
CASTLIGHT HEALTH	(888) 920-6390	mycastlight.com
DENTAL CIGNA Dental DHMO Delta Dental	 (800) 367-1037 (800) 524-0149	 cigna.com deltadentalin.com
VISION VSP	(800) 877-7195	vsp.com
LIFE INSURANCE Sun Life	(800) 247-6875	
EMPLOYEE ASSISTANCE PROGRAM Managed Health Network (MHN)	(800) 977-7637	mhn.com (company code: cno)
LONG-TERM DISABILITY CIGNA	(800) 352-0611	
FLEXIBLE SPENDING ACCOUNTS WageWorks	(877) 924-3967	wageworks.com
WASHINGTON NATIONAL INDIVIDUAL PRODUCTS Washington National Insurance Company–Health (after policy is in effect) Washington National Insurance Company–Life (after policy is in effect)	 (800) 541-2254 (800) 525-7662	
BANKERS LIFE LONG TERM CARE PRODUCTS	(765) 289-2264 ext. 150	

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