First Unum Life Insurance Company

Savills, Inc.

Your Group Long Term Care Insurance Plan

Policy No. 464355

Underwritten by First Unum Life Insurance Company

11-2022

This Certificate of Insurance is a part of the entire contract. This certificate is subject to the terms and conditions stated on the attached pages, all of which are part of the Summary of Benefits. The Summary of Benefits is a part of the Select Group Insurance Trust sitused in New York. Manufacturers Hanover Trust is the Trustee. The Summary of Benefits is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

Group Identification Number: 464355-001

Caution: If you completed an Application for Long Term Care Insurance which included evidence of insurability, the issuance of this insurance certificate was based upon your responses to the questions on your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, Unum has the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Unum at this address: First Unum Life Insurance Company, 99 Park Avenue, 6th Floor, New York, New York 10016.

- Insured persons are entitled to examine a copy of the Summary of Benefits during regular office hours at the Employer's place of business.
- Insured persons also are entitled to examine a copy of the Master Policy by contacting Unum directly.
- Throughout this certificate:
  - "you" or "your" means an active employee who is eligible for Unum benefits.

    Also, "you", "your" or "family member" means:

    - the spouse of an active employee (you must be legally married to your spouse),
    - the domestic partner of an active employee,
    - the natural, adoptive or step-parents/grandparents of an active employee, or
    - the natural, adoptive or step-parents/grandparents of a spouse or a domestic partner of an active employee.

    All persons, other than employees, must be less than 80 years of age at the time they apply for the insurance.
  - Unum means First Unum Life Insurance Company,
  - the terms "we", "our" and "us" refer to First Unum Life Insurance Company, and
  - Employer means Savills, Inc. and the following divisions, subsidiaries, and affiliated companies of Savills, Inc.:

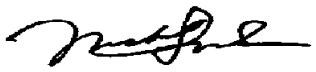
NONE

- You have a 30 day right to examine this certificate.

  If, after examining this certificate, you are not satisfied for any reason, you may withdraw your enrollment in this plan by returning this certificate within 30 days of its delivery to you. The certificate, together with a written request for such withdrawal, must be sent to:

  - **if you are an active employee or a spouse or a domestic partner of an active employee**, the Employer's Plan Administrator,
  - **if you are a family member, other than a spouse or a domestic partner of an active employee**, First Unum Life Insurance Company, 99 Park Avenue, 6th Floor, New York, New York 10016.

  Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.



President

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HIGHLIGHTS OF THE LONG TERM CARE INSURANCE PLAN

Eligibility and participation

You are eligible for the plan if you are an active employee of the Employer or one of the following divisions, subsidiaries or affiliated companies of the Employer.

NONE

Your family members are also eligible for the plan. Family members include your:

- spouse (you must be legally married to your spouse),
- domestic partner,
- natural, adoptive or step-parents/ grandparents, or
- spouse's or domestic partner's natural, adoptive or step-parents/grandparents.

Temporary or seasonal employees are excluded.

	Available July 1, 2002 Active Employees and Family Members- At your expense
Monthly Benefit Amount	
Residence	
- Long Term Care (LTC) Facility	$3,500 to $8,000 in $1,000 increments
- Assisted Living Facility	60% of the LTC Facility amount
Home or another similar place	
- Professional Home Care Services	50% of the LTC Facility amount
	OR
- Total Home Care	50% of the LTC Facility amount
Uncapped Compound Inflation Protection	5% compounded annually
Lifetime Maximum Amount	36X the LTC Facility amount **OR** 72X the LTC Facility amount **OR** Unlimited
Elimination Period	90 consecutive days

Evidence of Insurability Limits

- Monthly Benefit Maximum Amount(s) greater than $4,000; or
- Unlimited Lifetime Maximum Amount.

Evidence of Insurability satisfactory to Unum is required for amount(s) which exceed the evidence of insurability limits.

Cost

For information, see the discussion **"WHO PAYS FOR LONG TERM CARE INSURANCE?"**.

In making any benefits determination under the Summary of Benefits, Unum will have the discretionary authority both to determine an insured person's eligibility for benefits and to construe the terms of the Summary of Benefits.

INTRODUCTION TO THE UNUM PLAN

WHAT IS THE UNUM PLAN?

The Unum plan provides long term care insurance for you.

WHAT IS LONG TERM CARE INSURANCE?

Long term care insurance gives financial help if you need care as a result of a disability.

WHAT CAN YOU RECEIVE FROM LONG TERM CARE INSURANCE?

Insurance for long term care pays you a monthly payment if you become disabled. The amount of the monthly payment will depend on:

- the plan of coverage you choose;
- any options you choose, if available; and
- the place of residence used for care.

What is meant by disability and disabled?

Disability and disabled means you are unable to perform, without substantial assistance from another individual, at least two (2) activities of daily living; or you require substantial supervision by another individual to protect you from threats to health and safety due to severe cognitive impairment.

What are activities of daily living?

Activities of daily living are the activities you need to do to live independently. They are **BATHING, DRESSING, TOILETING, TRANSFERRING, CONTINENCE** and **EATING.**

- **BATHING** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
- **DRESSING** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **TOILETING** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **TRANSFERRING** means moving into or out of a bed, chair, or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- **CONTINENCE** means the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

- **EATING** means feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

What is substantial assistance?

Substantial assistance means stand-by assistance by another person without which you would not be able to safely or completely perform the activity of daily living.

What is severe cognitive impairment?

Severe cognitive impairment means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests, in:

- short or long term memory;
- orientation to people, places or time; and
- deductive or abstract reasoning.

Such deterioration or loss requires substantial supervision by another individual for the purpose of protecting you from harming yourself or others. The loss can result from a disability, Alzheimer's disease or other forms of dementia.

What is substantial supervision?

Substantial supervision means the presence of another individual for the purpose of protecting you from harming yourself or others.

WHO PAYS FOR LONG TERM CARE INSURANCE?

The coverage under this plan is contributory. This means you pay the full cost of your coverage under Unum's long term care insurance.

How is the cost determined?

The rate to be paid over the duration of your initial coverage or for any increases is based on your insurance age.

The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies under this type of insurance.

How do you pay the premiums?

- If you are an active employee:

  Your Employer will deduct premiums from each paycheck. If you leave employment with your Employer, you and your spouse or your domestic partner can continue the same coverage you each had under this plan on a direct billing basis. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group insurance ends?".

- If you are the natural, adoptive or step-parents/grandparents of an active employee, or the natural, adoptive or step-parents/grandparents of the spouse or the domestic partner of an active employee:

  You may have Unum direct bill you or your authorized representative for the premiums. If the Employer ends coverage, you can continue the same coverage you had under this plan. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group insurance ends?".

Is there a grace period?

The Employer, and insured persons who are direct billed, will be allowed a grace period of 45 days after the premium due date for the remittance of each premium amount due. If such premium amount is not remitted within the grace period, coverage will cancel at the end of the grace period.

Can coverage be reinstated if premium is not remitted within the grace period?

If your coverage terminates because a premium is not paid by the end of the grace period, you may request to reinstate your coverage at any time until six months from the coverage termination date.

In order to reinstate your coverage, the following requirements must be met:

- you must complete an Application for Long Term Care Insurance; and
- we must approve the Application for Long Term Care Insurance; and
- you must pay all unpaid premium.

If your Application for Long Term Care Insurance is approved, the reinstatement will take effect on the date your group coverage was terminated for non-payment of premiums.

Reinstatement WILL NOT cover any disability that is excluded by name or description in the Summary of Benefits.

Can coverage be reinstated if coverage is canceled for non-payment of premium because of a disability?

If you become disabled and your coverage terminates because premium is not paid by the end of the grace period, you may request to reinstate your coverage at any time until five months from the coverage termination date.

In order to reinstate your coverage, the following requirements must be met:

- you must provide proof that your disability occurred prior to the coverage termination date; and
- you must pay all unpaid premium.

If you meet these requirements, we will reinstate your coverage on the coverage termination date.

The reinstated coverage WILL NOT cover any disability that is excluded by name or description in the Summary of Benefits.

WILL PREMIUMS BE WAIVED WHILE YOU ARE RECEIVING A MONTHLY PAYMENT?

- **If you are receiving a "Long Term Care Facility" monthly payment:**

  When benefits become payable there will be no more cost for your coverage as long as you continue to:

  - be disabled; and
  - reside in a Long Term Care Facility.

- **If you are receiving an "Assisted Living Facility" monthly payment:**

  When benefits become payable there will be no more cost for your coverage as long as you continue to:

  - be disabled; and
  - reside in an Assisted Living Facility.

- **If your plan includes the "Professional Home Care" option and you are receiving a "Professional Home Care" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to:

  - be disabled; and
  - receive Professional Home Care.

  If you do not receive Professional Home Care for a period of 30 consecutive days, premium payments will again become due. To continue your coverage, premium payments **must** be resumed on the next premium due date following this 30 day period.

- **If your plan includes the "Total Home Care" option and you are receiving a "Total Home Care" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to be disabled.

WHO IS ELIGIBLE FOR THE PLAN?

Persons who may be eligible for the plan are:

Active employees of the Employer and their family members.

All persons, other than active employees, must be less than 80 years of age at the time they apply for this insurance.

What is an active employee?

An active employee means that you are working for the Employer:

- on a full-time basis for earnings that are paid regularly,
- for a minimum of 30 hours each week, and
- at the Employer's usual place of business, or
- at a location to which your job requires you to travel.

Temporary or seasonal employees are excluded.

What is a family member?

A family member means:

- the spouse of an active employee (you must be legally married to your spouse),
- the domestic partner of an active employee,
- the natural, adoptive or step-parents/grandparents of an active employee, or
- the natural, adoptive or step-parents/grandparents of a spouse or a domestic partner of an active employee.

All persons must be less than 80 years of age at the time they apply for this insurance.

IF YOU ARE AN ACTIVE EMPLOYEE, WHEN ARE YOU ELIGIBLE FOR COVERAGE, WHEN AND HOW DO YOU APPLY?

When do you become eligible?

You must be in an eligible class continuously for a certain period of time before you will be eligible for coverage. This period of time is called the waiting period.

If you are in an eligible class on or before July 1, 2002, there is no waiting period. You will be eligible for coverage on July 1, 2002.

If you enter an eligible class after July 1, 2002, the waiting period is the period ending on the February 1st on or next following your date of active employment. You will be eligible for coverage on the first day after you have been in an eligible class.

When can you apply for coverage?

- **If you are an active employee:**

  The period of time beginning on the date you become eligible for coverage and ending 30 days after that date is called your first enrollment period.

  - **During your first enrollment period,** you can apply for coverage without evidence of insurability for amounts that **do not** exceed evidence of insurability limits. Evidence of insurability will be required if you are applying for coverage amounts that **do** exceed the evidence of insurability limits, as shown on the HIGHLIGHTS OF THE LONG TERM CARE INSURANCE PLAN.

  - **After your first enrollment period,** you can apply for coverage with evidence of insurability.

- **If you are the spouse or the domestic partner of an active employee:**:

  You can apply for coverage, with evidence of insurability, any time after the date you become eligible for coverage.

How do you apply for coverage?

- **If you are an active employee:**

  - **During your first enrollment period:**

    You can apply for coverage by filling out a Benefit Elections Form.

    If you do not already have a Benefit Elections Form, you can get one from your Plan Administrator or Unum representative.

    After you fill out the Benefit Elections Form, be sure you sign and date it. The Benefit Elections Form will not be valid unless you sign and date it.

    Send the completed Benefit Elections Form to your Plan Administrator or directly to Unum to the address provided to you.

- **After your first enrollment period:**

  You can apply for coverage by filling out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from your Plan Administrator or Unum representative.

  Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability that it requests.

  After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

  Send the completed Benefit Elections Form and Application for Long Term Care Insurance to your Plan Administrator or directly to Unum to the address provided to you.

• **If you are the spouse or the domestic partner of an active employee:**

  You can apply for coverage by filling out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not already have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from your Plan Administrator or directly from Unum at the address provided to you.

  Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability it requests.

  After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

  Send the completed Benefit Elections Form and Application for Long Term Care Insurance to your Plan Administrator or directly to Unum to the address provided to you.

What is evidence of insurability?

Evidence of insurability includes not only the information you supply on the Application for Long Term Care Insurance, but also may include other proof of your medical history such as test results, medical exams, physicians' statements, etc. Unum may also request that an insurability assessment be performed. Unum will use the medical history as well as information obtained through any insurability assessment to help decide whether to accept or reject an Application for Long Term Care Insurance.

What is an insurability assessment?

An insurability assessment means a review done by Unum or its designated representative to help in evaluating your cognitive and functional status. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by Unum or its designated representative.

IF YOU ARE A FAMILY MEMBER, WHEN ARE YOU ELIGIBLE FOR COVERAGE, WHEN AND HOW DO YOU APPLY?

When do you become eligible?

You will be eligible for coverage on the date the employee is eligible for coverage.

If you are eligible for coverage as an active employee, you are only eligible for coverage as an employee.

When can you apply for coverage?

You can apply for coverage any time after the date you become eligible for coverage.

How do you apply for coverage?

To apply for coverage, you must fill out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not already have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from Unum at the address provided to you.

Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability it requests.

After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

Send the completed Benefit Elections Form and Application for Long Term Care Insurance directly to Unum to the address provided to you.

WHEN DOES COVERAGE BEGIN?

- **If you are an active employee:**
  - **Coverage applied for within your first enrollment period that does not exceed Evidence of Insurability limits** will begin on the latest of these dates:
    - the plan effective date,
    - 12:01 a.m. on the first day of the month that occurs on or next follows the month in which you become eligible for coverage, or
    - 12:01 a.m. on the first day of the month that occurs on or next follows the date you applied for coverage.
  - **Coverage applied for within your first enrollment period that does exceed Evidence of Insurability limits** will begin on the later of these dates:
    - the plan effective date if Unum approves your Application for Long Term Care Insurance on or before that date, or
    - 12:01 a.m. on the first of the month after Unum approves your Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or
    - 12:01 a.m. on the first of the second month after Unum approves your Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.
  - **Coverage applied for after your first enrollment period** will begin on the later of these dates:
    - 12:01 a.m. on the first of the month after Unum approves your Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or
    - 12:01 a.m. on the first of the second month after Unum approves your Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.
- **If you are the spouse or the domestic partner of an active employee:**

  Coverage applied for will begin on the later of these dates:
  - the plan effective date if Unum approves your Application for Long Term Care Insurance on or before that date, or
  - 12:01 a.m. on the first of the month after Unum approves your Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or
  - 12:01 a.m. on the first of the second month after Unum approves your Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.
- **If you are a family member:**

Coverage applied for will begin on the later of these dates:

- the plan effective date if Unum approves your Application for Long Term Care Insurance on or before that date, or
- 12:01 a.m. on the first of the month after Unum approves your Application for Long Term Care Insurance.

What if you are an active employee and absent from work on the date your coverage would normally begin?

Coverage will not begin for you if you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence on the date that the coverage would normally begin.

The coverage will begin at 12:01 a.m. on the date you return to work as an active employee.

What if you are a family member and you are totally disabled on the date your coverage would normally begin?

Coverage will not begin for you if you are totally disabled on the date that the coverage would normally begin.

The coverage will begin at 12:01 a.m. on the date that you no longer are totally disabled.

What does Unum mean by totally disabled if you are a family member?

You are totally disabled if, because of an injury or a sickness, you are unable to perform each of the duties or activities of a person of the same age and sex in good health.

What if the Employer rehires you?

Usually, you must be in an eligible class continuously for the length of the waiting period in order to become eligible for coverage.

However, if:

- you used to work for the Employer, and
- the Employer hires you again within one year from the date your employment ended,

Unum will count as part of the waiting period the time you were in an eligible class before your employment ended.

CAN COVERAGE BE CHANGED?

You can apply at any time to change coverage by filling out a new Benefit Elections Form and an Application for Long Term Care Insurance.

When will the changes take effect?

- **If you are an active employee or the spouse or the domestic partner of an active employee,** the changes will take effect on the later of these dates:

- 12:01 a.m. on the first of the month after Unum approves your Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or

- 12:01 a.m. on the first of the second month after Unum approves your Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.

- If **you are a family member**, the changes will take effect 12:01 a.m. on the first of the month after Unum approves your Application for Long Term Care Insurance.

Increases in the amount of insurance coverage will not take effect on the date they would normally take effect if:

- you are an active employee of Employer and you are absent from work on that date because you are injured, sick, temporarily laid off or on a leave of absence, or

- you are a family member and you are totally disabled on that date.

The increase or addition in insurance coverage will take effect at 12:01 a.m. on the date:

- you, an active employee of the Employer, return to work as an active employee, and

- you, a family member, no longer are totally disabled.

WHEN WILL GROUP COVERAGE THROUGH THE PLAN END FOR YOU?

When will coverage end?

Your coverage will end on the earliest of these dates:

- the date the Summary of Benefits under the policy ends,

- the date you no longer are in an eligible class,

- the date your class no longer is included for insurance,

- the date your total benefit payments equal your Lifetime Maximum Amount,

- the end of the period for which premiums were last remitted to Unum for your coverage,

- the date you no longer are an active employee with the Employer, or

- the date you die.

If your coverage ends for any reason other than your choice to have premium payments stopped for your coverage, you may continue coverage after the date it would normally end. For more information, see the discussion: "What happens when group coverage ends?".

What if you are absent from work at Savills, Inc.

If you are absent from work for any reason, you will continue to be covered for group coverage if the Employer continues to remit to Unum the premium for the coverage.

What happens when group coverage ends?

If group coverage ends, you or your authorized representative may elect portable coverage for you. This means that the same coverage you had under this plan can continue on a direct billing basis. Persons who are direct billed will automatically transfer to portable coverage.

But, if your group coverage ends because you chose to have premium payments stopped for your coverage, you may not elect portable coverage.

Any election for portable coverage must be made within 60 days of the date the group coverage would otherwise end. If so elected, you are a portable insured.

Any premium that applies must be paid directly to Unum by you for any portable coverage to be continued.

Also, the rate schedule for portable coverage may change in the future, depending on the overall use of the benefits by all covered persons or changes in the benefit levels or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies.

Can coverage be changed once on portability?

You can apply at any time to increase coverage by filling out a new Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability.

LONG TERM CARE INSURANCE

WHAT ARE LONG TERM CARE BENEFITS?

A long term care benefit will be paid to you if you become disabled according to the following schedule of long term care benefits:

- **Monthly Benefit Maximum(*)**

Residence Long Term Care Facility	Amounts in $1,000 units: . Minimum - 3.5 Units ($3,500) . Maximum - 8 Units ($8,000)
Assisted Living Facility	An amount equal to 60% of your "Long Term Care Facility" amount.

Home or another similar place
(There are two levels of home care from which to choose:)

- Professional Home Care Services, or	An amount equal to 50% of your "Long Term Care Facility" amount.
- Total Home Care	An amount equal to 50% of your "Long Term Care Facility" amount.

What is a Long Term Care Facility?

A Long Term Care Facility is:

- an institution, or a distinctly separate part of a hospital, that is licensed or certified as a nursing home (if licensing is required) or operates under the law as a nursing home to provide skilled, intermediate or custodial care and operates under state licensing laws and any other laws that apply; or
- any other institution that meets all of the following tests:
  - is operated as a health care facility under applicable state licensing laws and any other laws;
  - primarily provides nursing care under the orders of a physician;
  - operates under the supervision of a registered nurse or a licensed practical nurse;
  - regularly provides room and board and continuous 24 hour a day nursing care of sick and injured persons;
  - maintains a daily medical record of each patient who must be under the care of a physician;
  - is authorized to administer medication to patients on the order of a physician; and

- is not, other than incidentally:
    - a home for the mentally retarded, the mentally ill, the blind or the deaf, alcoholics or drug abusers, or
    - a hotel, a domiciliary care home or a residence; or

- a similar institution approved by Unum.

The confinement must be:

- prescribed or recommended by a physician, and
- recommended, at least annually during the confinement, by your physician as necessary due to a disability.

What is an Assisted Living Facility?

An Assisted Living Facility is:

- an institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage in providing ongoing care and services to a minimum of 3 inpatients in one location and operates under state licensing laws and any other laws that apply; or
- any other institution that meets all of the following tests:
    - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a disability;
    - has an employee on duty at all times who is awake, trained and ready to provide care;
    - provides 3 meals a day, including special dietary requirements;
    - operates under applicable state licensing laws and any other laws that apply;
    - has formal arrangements for the services of a physician or nurse to furnish medical care in the event of an emergency;
    - is authorized to administer medication to patients on the order of a physician; and
    - is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers; or

      NOTE: These requirements are typically met by assisted living facilities that are either free standing facilities or part of a life care community. In general, they are not met by individual residences, boarding homes or independent living units.

- a similar institution approved by Unum.

What is Professional Home Care?

Professional Home Care means:

- Skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services provided by a Home Health Care Provider; and
- Adult Day Care provided by:
  - a Home Health Care Provider;
  - an Adult Day Care Facility which operates under applicable state licensing laws and any other laws that apply; or
  - an Adult Day Care Facility which meets the following tests:
    - Operates a minimum of 5 days a week;
    - Remains open for at least 6 hours a day;
    - Is not an overnight facility;
    - Maintains a written record of care on each patient;
    - Includes a plan of care and record of services provided;
    - Has a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
    - Has established procedures for obtaining appropriate aid in the event of a medical emergency; and
    - Provides a range of physical and social support services to adults.
  - Hospice Care.

The treatment and services you receive must be provided pursuant to a written plan of care developed by a licensed health care practitioner.

Professional Home Care does not include services performed by your family members' spouse, daughter, son, parent, sister, brother, grandparent or grandchild through a Home Health Care Provider or an Adult Day Care Facility.

What is a Home Health Care Provider?

A Home Health Care Provider is:

- an organization which is licensed or certified by the appropriate licensing agency of the state where Professional Home Care will be provided; or
- certified as a home health care organization as defined under Medicare; or

- any other organization that meets all of the following tests:
  - primarily provides skilled nursing care and other therapeutic services;
  - has standards, policies and rules established by a professional group which is associated with the organization;
  - includes at least one physician and one registered nurse;
  - maintains a written record of care on each patient; and
  - includes a plan of care and record of services provided; or
- a similar organization approved by Unum.

What is hospice care?

Hospice care means a formal program of care for terminally ill patients whose life expectancy is less than 6 months, provided on an inpatient basis and directed by a physician in a hospice care facility that is licensed, certified or registered in accordance with state law.

What is a licensed health care practitioner?

A licensed health care practitioner means any physician, and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

What is Total Home Care?

Total Home Care provides financial help in case you need care at home or another similar place due to a disability.

Total Home Care means:

- visits to your residence by a Home Health Care Provider to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services;
- Adult Day Care;
- Hospice Care; or
- care provided by an informal caregiver, such as your friends or relatives.

The treatment and services you receive must be provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner.

What is the Elimination Period?

The Elimination Period is the number of consecutive days during which you must continue to qualify to receive monthly payments before benefits can become payable. For information on how to qualify to receive monthly payments see the discussion **"HOW DO YOU QUALIFY TO RECEIVE MONTHLY PAYMENTS?"**.

The Elimination Period under the Summary of Benefits for this certificate is 90 consecutive days.

- **If you are receiving "Professional Home Care"**, each calendar week that you receive at least one day of Professional Home Care will be counted as seven days towards completing the Elimination Period.

  If you continue to remain at home or another similar place and do not receive Professional Home Care for at least one day within a calendar week, the Elimination Period will begin again.

- **If your plan does not include "Professional Home Care" or "Total Home Care"**, the entire Elimination Period must be completed while residing in a Long Term Care Facility.

What is the Lifetime Maximum Amount you can receive under the Summary of Benefits?

The Lifetime Maximum Amount is the maximum Unum will pay you for all long term care benefits. You have your own Lifetime Maximum Amount.

The Lifetime Maximum Amount under the Summary of Benefits for this certificate is:

Lifetime Maximum Amount	36X the LTC Facility amount **OR** 72X the LTC Facility amount **OR** Unlimited

CAN BENEFITS BE INCREASED TO PROTECT AGAINST INCREASING COST?

Yes.

- **If you choose the uncapped Compound Growth Inflation Protection Option at the time of enrollment,** your initial amount of coverage will be increased by 5% on January 1st of the next calendar year. Subsequent 5% increases will be added, each January 1st after that, to your amount of coverage in effect on the last day of the previous calendar year.

- **If you choose the uncapped Compound Growth Inflation Protection Option when you apply for additional coverage,** your additional amount of coverage will be increased by 5% on January 1st of the next calendar year. Subsequent 5% increases will be added, each January 1st after that, to your additional amount of coverage in effect on the last day of the previous calendar year.

- **FOR EXAMPLE:** A monthly benefit amount of $1,000 will be increased by 5% for an amount of coverage equal to $1,050.00 for the next calendar year; 5% of $1,050.00 for an amount of coverage equal to $1,102.50 for the following calendar year; and so on.

As long as your coverage remains in effect, these inflation increases will occur automatically regardless of your health or whether or not you have used your benefits.

No inflation increases will be made after the end of the period for which premiums were last remitted to Unum for your coverage.

HOW DO YOU QUALIFY TO RECEIVE MONTHLY PAYMENTS?

You will qualify to receive monthly payments from Unum after:

- you become disabled;

- you are receiving services in a Long Term Care Facility or Assisted Living Facility; or you are receiving Professional Home Care Services if your plan includes a Professional Home Care Services benefit; or you are receiving Total Home Care if your plan includes a Total Home Care benefit;

- you have satisifed your Elimination Period; and

- a physician has certified that you are unable to perform (without substantial assistance from another individual) two or more ADLs for a period of at least 90 days, or that you require substantial supervision by another individual to protect you and others from threats to health or safety due to severe cognitive impairment. You will be required to submit a physician certification every 12 months.

The treatment and services you receive for your disability must be provided pursuant to a written plan of care developed by a licensed health care practitioner.

If you have an existing ADL loss or severe cognitive impairment on your effective date of coverage, that loss or impairment will be eligible for coverage only if you recover from that loss or impairment. We must receive acceptable proof of your ADL or severe cognitive recovery, such as a physician's statement or an assessment.

What is a physician?

A physician is a person who is operating within the scope of his/her license, and is either:

- licensed to practice medicine and surgery and prescribe and administer drugs; or
- legally qualified as a medical practitioner and required to be recognized, under this plan for insurance purposes, according to the insurance laws of the governing jurisdiction.

Unum will consider a person to be a physician only when the person is performing tasks that are within the limits of the person's medical license.

Unum will not recognize:

- you, or
- your or your family member's spouse, daughter, son, parent, sister, brother, grandparent or grandchild

as physicians for claims that you make to Unum for long term care insurance.

WHEN WILL YOU RECEIVE MONTHLY PAYMENTS?

You will receive monthly payments from Unum once you qualify. For information on how to qualify to receive long term care monthly payments, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE MONTHLY PAYMENTS?"**.

HOW MUCH WILL UNUM PAY IF YOU BECOME DISABLED?

If you become disabled and qualify to receive monthly payments, Unum will send the payment to you each month. To determine the amount Unum will pay you each month see **"WHAT ARE LONG TERM CARE BENEFITS?"**.

If you qualify for a "Long Term Care Facility" payment for a period that is less than one month, Unum will pay 1/30th of your "Long Term Care Facility" Monthly Benefit Maximum for each day that you:

- are disabled; and
- reside in a Long Term Care Facility.

If you qualify for an "Assisted Living Facility" payment for a period that is less than one month, Unum will pay 1/30th of your "Assisted Living Facility" Monthly Benefit Maximum for each day that you:

- are disabled; and
- reside in an Assisted Living Facility.

If your plan includes the "Professional Home Care" option and you qualify for a "Professional Home Care" payment for a period that is less than one month, Unum will pay 1/30th of your "Professional Home Care" Monthly Benefit Maximum for each day that you:

- are disabled; and
- receive Professional Home Care.

If your plan includes the "Total Home Care" option and you qualify for a "Total Home Care" payment for a period that is less than one month, Unum will pay 1/30th of your "Total Home Care" Monthly Benefit Maximum for each day that you are disabled.

For information on how to qualify to receive monthly payments, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE MONTHLY PAYMENTS?".**

HOW LONG WILL UNUM CONTINUE TO PAY YOU BENEFITS?

Unum will continue monthly payments to you until the earliest of the following dates:

- the expiration of your physician certification,
- the date you no longer are disabled,
- the date you no longer qualify to receive a monthly payment under the long term care plan of coverage you chose,
- the date your total benefit payments equal the Lifetime Maximum Amount, or
- the date you die.

CAN YOU RECEIVE ANY PAYMENTS WHILE YOU ARE RECEIVING RESPITE CARE IF UNUM IS NOT YET MAKING LONG TERM CARE MONTHLY PAYMENTS?

Yes. If you qualify for a Home or another similar place monthly benefit but are not yet receiving monthly payments because you:

- have not yet completed the Elimination Period; or
- have completed the Elimination Period but have chosen to postpone receipt of benefits in order to preserve your Lifetime Maximum Amount

Unum will make payments to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your Home or another similar place Monthly Benefit Maximum for each day that you receive respite care. Payments made to you for respite care will reduce your Lifetime Maximum Amount under the Summary of Benefits.

You **do not** have to complete the Elimination Period for respite care payments to become payable.

Premiums are **not** waived while you are receiving a payment for respite care.

What is respite care?

Respite care means care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities.

Respite care may be provided to you by:

- a formal caregiver, such as a Home Health Care Provider, an Adult Day Care Facility, a registered nurse, a licensed practical nurse,or
- an informal caregiver such as a friend or relative.

WHAT IF YOU BECOME DISABLED AGAIN AFTER RECEIVING LONG TERM CARE PAYMENTS FROM UNUM?

If the disability begins after the date Unum stopped making payments to you for the previous loss, you **do not** have to satisfy a new Elimination Period. Unum will pay long term care benefits to you until the earliest of the dates listed in the discussion **"HOW LONG WILL UNUM CONTINUE TO PAY YOU BENEFITS?".**

WHAT IS NOT COVERED FOR LONG TERM CARE?

Unum will not make payments to you for:

- disabilities caused by war (whether declared or not) or any act of war,
- disabilities caused by attempted suicide or self-destruction,
- disabilities caused by committing or attempting to commit a felony,
- disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- any days over fifteen days during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention),
- confinement in a facility for which no charge is normally made in the absence of insurance, except Medicaid,
- disabilities caused by alcoholism,
- disabilities caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.), or
- disabilities caused by psychological or psychiatric conditions which include:

- depression,
- generalized anxiety disorders,
- personality disorders,
- schizophrenia, or
- manic depressive disorders

whether treated by drugs, counseling or other forms of therapy.

However, Unum will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.

WILL UNUM MAKE ANY PAYMENT TO YOU IF YOU HAD A CONDITION BEFORE UNUM'S LONG TERM CARE COVERAGE BEGINS?

Unum will not make any payments to you for any disability that is caused by, contributed to by, or results from a preexisting condition.

A preexisting condition is any condition that exists for which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition, or
- took drugs or medicines that were prescribed for the condition,

during the six month period right before your coverage began.

A condition will cease to be a preexisting condition six months after your coverage begins.

This preexisting conditions limitation will apply to all insurance that does not require evidence of insurability.

WILL TRANSFER OF GROUP INSURANCE CARRIERS CAUSE A LOSS OF COVERAGE DUE TO A PREEXISTING CONDITION?

To prevent loss of coverage due to a transfer of group insurance carriers, coverage of a preexisting condition will be provided under this plan if you:

- were insured under the prior carrier's group long term care insurance plan at the time of transfer; and
- are insured under this plan on its effective date.

The benefits you qualify for under this plan will become payable when you have satisfied the preexisting condition limitation under the plan or the prior carrier's group long term care insurance plan, taking into consideration continuous time insured under both plans.

No benefits will become payable under this plan if you cannot satisfy the preexisting condition limitation of either this plan or the prior carrier's group long term care insurance plan.

CAN UNUM HELP YOU REGAIN THE ABILITY TO INDEPENDENTLY ENGAGE IN THE ACTIVITIES OF DAILY LIVING?

Unum may suggest that you participate in a case management or rehabilitation program designed to help regain the ability to independently engage in the activities of daily living. The actual expenses that Unum will pay for and the terms of the case management or rehabilitation program will be subject to mutual agreement between Unum and you or your authorized representative. This agreement will be outlined in a written plan of case management or rehabilitation.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS INSURANCE BE USED?

Unum considers any statements you make for insurance in a signed application to be complete and true to the best of your knowledge and belief. If any of these statements are not complete and/or not true at the time they are made, Unum can:

- reduce or deny any claim, or
- cancel insurance from the original effective date.

Unum must use only the statements made in the signed application(s) as a basis for doing this.

Unum can take these actions only in the first 2 years your insurance is in force.

CAN UNUM RESCIND COVERAGE OR DENY A VALID CLAIM FOR MISREPRESENTATION?

For a certificate that has been in force for less than six (6) months, Unum may rescind coverage or deny an otherwise valid insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

For a certificate that has been in force for at least six (6) months but less than two (2) years, Unum may rescind coverage or deny an otherwise valid insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

After a certificate has been in force for two (2) years, it is not contestable upon the grounds of misrepresentation alone; such a certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to his/her health.

CAN THE EMPLOYER ACT AS UNUM'S AGENT?

For all purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed Unum's agent.

IS THE SUMMARY OF BENEFITS GUARANTEED RENEWABLE?

The Summary of Benefits is guaranteed renewable on each Anniversary Date.

What does Unum mean by Guaranteed Renewable?

Guaranteed renewable means that the Summary of Benefits will continue in force subject to the following conditions:

- the Employer promptly gives Unum any information that Unum requires,
- the Employer performs all of its obligations that relate to the Summary of Benefits, and
- the Employer continues to remit all premiums due within the grace period.

CLAIM INFORMATION

WHEN DO YOU FILE A CLAIM FOR PAYMENTS?

Written notice of a claim must be given within 30 days after the date that your disability began or as soon as it is reasonably possible to do so.

If you do not have a Long Term Care Notice of Claim Form, you can get one from the Employer's Plan Administrator, or your Unum representative, or you can notify Unum in writing that you want to make a claim. If you do not receive the form from Unum within 15 days after writing, send Unum proof of the claim without the form.

You must send Unum proof of claim for long term care payments no later than 90 days after the date your disability began. If you cannot send Unum proof within this 90-day period, you must send Unum proof as soon as it is reasonably possible to do so, but in no event more than one year after the time this proof is required.

The proof of your claim must include:

- the date your disability occurred;
- the cause of your disability;
- the extent of your disability;
- certification by a physician that you are unable to perform (without substantial assistance from another individual) two or more ADLs for at least 90 days, or that you require substantial supervision by another individual to protect yourself and others from threats to health or safety due to severe cognitive impairment;
- your written plan of care developed by a licensed health care practitioner;
- such other proof as we may deem necessary.

You must give Unum proof of continued disability at intervals requested by us. Such proof must be given within 30 days of our request. If it is not possible for you to give proof of continued disability within this 30-day period, it must be given as soon as reasonably possible. However, proof of continued disability must be given no later than one year after the time proof is otherwise required.

If your claim is for a "Professional Home Care" monthly payment, Unum must also receive proof of the Professional Home Care provided to you.

HOW DO YOU FILE A CLAIM FOR PAYMENTS?

You or your authorized representative must fill out, detach and mail the Notice of Claim postcard to Unum. This postcard is provided as an attachment to the Long Term Care Claim Form.

You or your authorized representative must also fill out the Long Term Care Claim Form and send it to Unum. If you have enough information to fully complete and send the Long Term Care Claim Form, you do not need to send the Notice of Claim postcard separately.

Once Unum receives the Notice of Claim postcard and/or the Long Term Care Claim Form, a Claims Representative will contact you or your authorized representative to review the information on the form(s) and answer any questions you may have.

As part of proof of claim, Unum may request that a claims assessment be performed.

Unum may also send your attending physician(s) a Long Term Care Attending Physician's Initial Statement Form to fill out and send to Unum. In some cases, Unum may require additional Attending Physician's Progress Statements if you continue to be disabled.

After you have filed a claim, Unum may also require you to be examined by a physician or other medical practitioner of Unum's choice. Unum will pay for the examination. Unum can require an examination as often as it is reasonable to do so.

Unum may require you or your authorized representative to give it authorization to obtain additional medical and nonmedical information as part of the proof of claim.

What is a claims assessment?

A claims assessment means a review done by Unum or its designated representative to help in evaluating the status of your disability. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by Unum or its designated representative.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or an authorized representative may not sue on your claim before 60 days after proof of loss has been given to Unum. You or an authorized representative may not sue after 3 years from the time proof of loss is required.

WHEN WILL UNUM BEGIN TO SEND YOU PAYMENTS?

When Unum receives acceptable proof of your claim for payments, Unum will begin to send you payments if you have qualified. For more information, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE MONTHLY PAYMENTS?"**.

Unum will send you a lump sum payment to cover the period of time between the day you became eligible for benefit payments and the day you were approved for benefit payments. Unum will then send you a payment each month during any remaining period you are disabled for which you are eligible to receive payments. For more information about how long Unum will continue to send payments, see the discussion **"HOW LONG WILL UNUM CONTINUE TO PAY YOU BENEFITS?"**.

HOW DOES UNUM'S RIGHT OF RECOVERY AFFECT YOUR CLAIM?

Unum has the right to recover any overpayments made because of any error Unum makes in processing your claim.

Additional Summary Plan Description Information

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the Summary Plan Description. The Summary Plan Description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your Certificate of Coverage and the information contained in this document.

Name of Plan:
Savills, Inc. Plan

Name and Address of Sponsoring Organization:
Savills, Inc.
300 Park Avenue
New York, NY 10022

Plan Identification Number:
a. Sponsoring Organization IRS Identification #: 13-1813318
b. Plan #: 510

Type of Welfare Plan:
Long Term Care

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benfits issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address and Telephone No.:
Savills, Inc.
300 Park Avenue
New York, NY 10022
(212) 326-1006

Savills, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Same as above

Service of legal process may also be made upon the Plan Administrator, and any Trustee of the Plan.

Funding and Contributions:

The Plan is funded by insurance issued by First Unum Life Insurance Company 99 Park Avenue, 6th Floor, New York, New York 10016 (hereinafter referred to as "Unum") under policy number/identification number 464355 001. Contributions to the Plan are made as stated in the in the "SCHEDULE OF LONG TERM CARE INSURANCE BENFITS" in the Certificate of Coverage.

SPONSORING ORGANIZATION'S RIGHT TO AMEND THE PLAN

The Sponsoring Organization reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

SPONSORING ORGANIZATION'S RIGHT TO REQUEST POLICY CHANGE

The Sponsoring Organization can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Sponsoring Organization.

Unum can terminate the Summary of Benefits if:

- the Sponsoring Organization does not promptly give Unum any information that Unum requires; or
- the Sponsoring Organization fails to perform any of its obligations that relate to the Summary of Benefits.

However, Unum cannot non-renew or otherwise terminate this Summary of Benefits because the insured persons grow older or because of the insured persons use of benefits.

The Sponsoring Organization can terminate the Summary of Benefits on any date. To terminate the Summary of Benefits, the Sponsoring Organization must deliver written notice to Unum at least 45 days before the termination date.

If the Sponsoring Organization and Unum both agree, this Summary of Benefits may be terminated less than 45 days after the Sponsoring Organization or Unum gives notice of termination. However, this Summary of Benefits will not be terminated during any period for which the Sponsoring Organization has remitted the premium.

The Summary of Benefits will automatically terminate if the Sponsoring Organization does not remit all premiums due within 45 days - the grace period - after

the date the premium is due. The Summary of Benefits will terminate at 12:00 midnight on the 45th day after the premium is due.

The Sponsoring Organization must remit all of the premiums for the entire time that the Summary of Benefits is in effect and will be liable to Unum for any premiums that it does not remit.

If the Summary of Benefits is terminated, Unum will still pay any payable claim for an insured person's chronic illness which began while the Summary of Benefits was in effect. was in effect.

Unum will pay this claim until the earliest of the dates listed in the certificate under "HOW LONG WILL UNUM CONTINUE TO PAY YOU FOR YOUR LONG TERM CARE BENEFITS?".

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. Unum must receive a completed claim form. The form must be completed by you or your authorized representative. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIM PROCEDURES

The time periods provided in this section will apply to claims procedures under the Summary of Benefits unless a shorter time period is stated in the Summary of Benefits.

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

1. the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and

3. a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

The time period provided in this section for submitting an appeal will apply unless a longer time period for submitting an appeal is stated in the Summary of Benefits.

The time period provided in this section for making a final appeal decision will apply unless a shorter time period for making a final appeal decision is stated in the Summary of Benefits.

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

1. submit a request for review, in writing, to Unum;

2. upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

3. submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notices of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials. This does not apply if the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, (for example, if the courts find your claims frivolous) the court may order you to pay these costs and fees.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligiblity for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in the evaluating those decisions.