GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

Port Jefferson UFSD

Deputy Superintendent, Assistant Superintendent for Curriculum & Instruction, and Executive Director of Human Resources

FIRST RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: 590 Madison Avenue, 29th Floor, New York, New York 10022

TABLE OF CONTENTS

CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 165100 issued to Port Jefferson UFSD, the Policyholder.

When loss of life covered under the Policy occurs, we will pay the amount stated on the Schedule of Benefits to the named beneficiary, subject to provisions entitled Beneficiary and Facility of Payment.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

Secretary

President

GROUP LIFE INSURANCE CERTIFICATE

READ YOUR POLICY CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED.
IN CASE OF ANY DOUBT, WRITE YOUR COMPANY FOR FURTHER EXPLANATION.

This Group Life Certificate replaces any previous Group Life Certificates and is dated April 1, 2022.

SCHEDULE OF BENEFITS

EFFECTIVE DATE: December 31, 2021

ELIGIBLE CLASSES: Each active and retired Full-time Deputy Superintendent, Assistant Superintendent for Curriculum & Instruction, and Executive Director of Human Resources, except any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The day you become eligible.

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE:

Basic Life and Accidental Death and Dismemberment: $300,000.

The retiree benefit amount is based on the amount inforce at the time of retirement and not the benefit inforce on the policy at the time of death. Retirees are not eligible for increases made to the policy after they have retired.

ACTIVE EMPLOYEES:

The Amount of Basic Life Insurance will be reduced to $70,000 at age 70.

The Amount of Accidental Death and Dismemberment Insurance will be reduced to $70,000 at age 70 and terminates at retirement.

RETIREES:

If you are a former employee of the Policyholder, and prior to your retirement you:

1) worked as a full-time employee; and
2) were insured as an active employee,

to be considered a retired employee, you must be age 55 or over and actually be receiving a retirement, pension or annuity benefit under the Systems Retirement Plan immediately after active employment ceases or be less than age 55 and retiring under the New York State Retirement Incentive. Your benefit shall be reduced as follows:

The amount of Basic Life Insurance will be reduced by 50% of the pre-age 65 amount at age 65 and reduces to $2,000 at age 70.

*The following provisions of the Policy do not apply to retirees: Actively at Work, Continuation of Individual Insurance, Individual Reinstatement and Accidental Death and Dismemberment Insurance.

The Life amount will be reduced by any benefit paid under the Accelerated Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Changes in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the month coinciding with or next following the date of the change, provided you are Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work in an Eligible Class for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

DEFINITIONS

"We," "us" and "our" means First Reliance Standard Life Insurance Company.

"You," "your" and "yours" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at work" and active work" means actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

"Full-time" means working for the Policyholder for a minimum of 21 hours during your regularly scheduled work week.

"The date you retire" or "retirement" means the effective date of your:

(1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
(2) retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
(3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act while you are receiving the retirement pension benefits from the Policyholder.

"Total Disability" as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means your complete inability to engage in any type of work for wage or profit for which you are suited by education, training or experience.

"Loss" as used in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section, with respect to:

(1) hand or foot, means the complete severance through or above the wrist or ankle joint;

(2) the eye, speech or hearing, means total and irrecoverable loss thereof.

"Injury" means accidental bodily injury that is caused directly and independently of all other causes by accidental means and which occurs while your coverage under the Policy is in force.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract between the Policyholder and us is the Policy, the Policyholder's application (a copy of which is attached at issue), and any riders, endorsements and amendments and the Certificate of Insurance. The rights of the Policyholder, your rights or the rights of any beneficiary shall not be affected by any provision other than one contained in the Policy, any riders, endorsements or amendments signed by the Policyholder and us or in the Policyholder's application attached to the Policy.

CHANGES

No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing. It must also be signed by one of our executive officers and attached to the Policy.

INCONTESTABILITY

Any statement made by you will be deemed a representation, not a warranty. We cannot contest the Policy after it has been in force for two (2) years, except for non-payment of premiums. No statement made by you can be used in a contest after your insurance has been in force during your lifetime for two (2) years. No statement by you can be used in a contest unless it is in writing and signed by you and given to you, your beneficiary and such statement reflects a material misrepresentation.

RECORDS MAINTAINED

The Policyholder must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR

If a clerical error is made, it will not affect your insurance. No error will begin or continue your insurance prior to the date it should begin or beyond the date it should end under the Policy terms, if the error had not been made.

MISSTATEMENT OF AGE

If your age is misstated, the premium will be equitably adjusted. If your insurance is affected by the misstated age, the insurance coverage will be changed to the amount you are entitled to at your correct age.

ASSIGNMENT

Where there is no Third Party ownership, you may assign your interest under the Policy. If you do, all rights under the Policy are transferred to the new owner. If there is an irrevocable beneficiary, you must have his/her written consent to assign the insurance. No assignment will affect us unless it is in writing and is sent to us at our Office. When we receive the assignment, it will take effect as of the date it is signed. We are not liable for any action we take before we record it. We're not responsible for the validity of the assignment.

Where Third Party ownership applies, we will recognize the Third Party owner designated by you. That person will be considered the sole owner with all rights of ownership. These include the right to change the beneficiary, receive payment of claims and assign the insurance.

CONFORMITY WITH STATE LAWS

Any section of the Policy, which on its effective date, conflicts with the laws of the state in which the Policy is issued, is amended by this provision. The Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE

We will send to the Policyholder an individual certificate for you. The certificate will outline the insurance coverage and to whom benefits are payable. Nothing in the Policy impairs or invalidates any rights granted to you as stated in certificate or by New York law and benefits provided under the Policy and certificate will not be less than those required by the state where the certificate is delivered and by New York law.

TERMINATION OF THE POLICY

The Policyholder may cancel the Policy at any time. The Policy will be cancelled on the date we receive the Policyholder's letter or, if later, the date requested in the Policyholder's letter.

We may cancel the Policy if:

(1) the premium is not paid at the end of the grace period; or
(2) the number of Insureds is less than the Minimum Participation Number on the Schedule of Benefits; or
(3) the percentage of eligible persons insured is less than the Minimum Participation Percentage on the Schedule of Benefits.

If we cancel because of (1) above, the Policy will be cancelled at the end of the grace period. If we cancel because of (2) or (3) above, we will give you sixty (60) days written notice prior to the date of cancellation.

The Policyholder will still owe us any premium that is not paid up to the date the Policy is cancelled. We will return, pro-rata, any part of the premium paid beyond the date the Policy is cancelled.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be the Policyholder's employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, the insurance for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or

(2) the date you apply, if you apply within thirty-one (31) days from the date you first met the eligibility requirements; or

(3) the date we approve any required proof of good health. We require proof of good health if you apply:

- (a) after thirty-one (31) days from the date you first become eligible; or
- (b) after you terminated this insurance but you remained in a class eligible for this insurance; or
- (c) for an Amount of Insurance greater than the guaranteed issue Amount of Insurance shown on the Schedule of Benefits, if applicable; or
- (d) for an Amount of Insurance greater than you were insured for under the prior group life insurance plan carrier, if applicable; or
- (e) after being eligible for coverage under a prior group life insurance plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or

(4) the date premium is remitted.

Proof of good health forms are available from us upon request. It is the Policyholder's responsibility to provide proof of good health forms to you when required.

Changes in your Amount of Insurance are effective as shown on the Schedule of Benefits.

If you are not Actively at Work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to Active Work in an Eligible Class for one full day.*

TERMINATION OF INSURANCE: Your insurance will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or**

(3) the end of the period for which premium has been paid for you; or

(4) the date you are no longer Actively at Work (except as provided in the Continuation of Individual Insurance or Waiver of Premium provisions).

CONTINUATION OF INSURANCE: In each instance listed below, such continuation shall be at the Policyholder's option, but must be according to the plan which applies to all Insureds in the same way:

(1) If you are on layoff or approved Leave of Absence, you may continue your Amount of Insurance as long as premium is paid.
(2) If you are absent from work due to an injury or sickness, you may continue your Amount of Insurance as long as premium is paid.

Continuation is available in addition to Conversion. The Conversion privilege may be exercised at any time during this Continuation period.

REINSTATEMENT: Insurance may be reinstated if you were:

(1) on an approved leave of absence, or

(2) on a temporary lay-off.

You must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

The insurance will go into effect on the day you return to Active Work for one full day. If you return after having resigned or having been discharged, you will be required to fulfill the Eligibility Requirements of the Policy again.

If you request insurance after previously terminating insurance at your request or for failure to pay premium when due, proof of good health must be approved by us before your insurance coverage may be reinstated.

* Not Applicable to retirees.
** Insurance will not terminate at retirement, the amount of insurance will be as shown on the Schedule of Benefits.

CONVERSION PRIVILEGE

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

   (1) The policy will, at your option, be on any one of our forms, other than term life insurance (except as described in C below). It will be the standard type issued by us for the age and amount applied for;

   (2) The policy issued will be for an amount not over what you had before you terminated;

   (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and

   (4) Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will be less any amount you are entitled to under any other group life policy issued or reinstated by us or another insurance company within forty-five (45) days after the date insurance coverage ceases.

C. An individual term Life Insurance Policy may, at your option, be issued for a period of one year immediately preceding the issuance of a Life Insurance Policy described in A or B above. The same rules as in A above will be used.

D. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

E. If you die during the time in which you are entitled to apply for an individual policy and you did not apply for such policy before your death, then we will pay the benefit under the Group Policy that you were entitled to convert.

F. Any policy issued with respect to A, B, C or D above will be put in force at the end of the thirty-one (31) day period in which application must be made.

NOTICE OF CONVERSION

G. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right within fifteen (15) days before or after the termination or reduction of your insurance. Such notice must be: (1) in writing; and (2) presented or mailed to you at your last known address by the Policyholder or by us at your last known address furnished to us by the Policyholder. If you are given notice more than fifteen (15) days after termination or reduction but less than ninety (90) days, you will have an additional period within which to convert. This additional period will end forty-five (45) days after you are given notice. However, this period will not extend beyond ninety (90) days after the date of termination or reduction of the insurance. This insurance will not be continued beyond the period provided above.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by you to receive benefits at your death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date you sign it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if you wish to change the designation. His/her consent is also not needed to make any changes in the Policy.

If the beneficiary dies at the same time as you, or within fifteen (15) days after your death but before we received written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

(1) your legal spouse;
(2) your surviving child(ren) (including legally adopted child(ren)), in equal shares;
(3) your surviving parents, in equal shares;
(4) your surviving siblings, in equal shares; or, if none of the above,
(5) your estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to $500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

SETTLEMENT OPTIONS

You may elect a different way in which payment of the Amount of Insurance can be made. You must provide a written request to us, for our approval, at our Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under $2,000 or option payments of less than $20.00 each are not eligible.

If no instructions for a settlement option are in effect at the death of an Insured, the beneficiary may make the election, with our consent.

OPTION A – FIXED TIME PAYMENT OPTION

Equal monthly payments will be made for any period chosen, up to thirty (30) years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change it. This change will apply only to requests for settlement elected after this change.

Option A Table
Minimum Monthly Payment Rates for each $1,000 Applied

Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment
1	$83.71	7	$12.32	13	$6.83	19	$4.81	25	$3.76
2	42.07	8	10.83	14	6.37	20	4.59	26	3.64
3	28.18	9	9.68	15	5.98	21	4.40	27	3.52
4	21.24	10	8.75	16	5.63	22	4.22	28	3.41
5	17.08	11	7.99	17	5.33	23	4.05	29	3.31
6	14.30	12	7.36	18	5.05	24	3.90	30	3.21

OPTION B - FIXED AMOUNT PAYMENT OPTION

Each payment will be for an agreed fixed amount. The amount of each payment may not be less than $10.00 for each $1,000 applied. Interest will be credited each month on the unpaid balance and added to it. This interest will be at a rate set by us, but not less than the equivalent of 1% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

OPTION C - INTEREST PAYMENT OPTION

We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 1% per year.

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the proper representative of the beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the three (3) set out above may be made. A mutual agreement must be reached between the individual entitled to elect and us.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

(1) you become totally disabled prior to age 60;
(2) the Total Disability begins while you are insured;
(3) the Total Disability begins while the Policy is in force;
(4) the Total Disability lasts for at least 9 months;
(5) the premium continues to be paid; and
(6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Policyholder is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask you to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. You may be required to be examined by a Physician approved by us as part of the proof. We will not require you to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life and accidental death and dismemberment coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for you will cease on the earliest of:

(1) the date you no longer meet the definition of Total Disability; or
(2) the date you refuse to be examined; or
(3) the date you fail to furnish the required proof of Total Disability.

You may use the conversion privilege when this extension ceases. Please refer to the Notice of Conversion found on the Conversion Privilege page for rules and requirements. You are not entitled to conversion if you return to work and are again eligible for the insurance under the Policy. If you use the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Nothing in this section will change or affect any of the terms of the Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

LOSS OF:	**AMOUNT OF INSURANCE:**
Life	The Full Amount
Both Hands	The Full Amount
Both Feet	The Full Amount
The Sight of Both Eyes	The Full Amount
Speech and Hearing	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and the Sight of One Eye	The Full Amount
One Foot and the Sight of One Eye	The Full Amount
One Hand	One-Half of the Amount
One Foot	One-Half of the Amount
Speech or Hearing	One-Half of the Amount
The Sight of One Eye	One-Half of the Amount

TOTAL LOSS OF USE OF:	**AMOUNT OF INSURANCE:**
Both Arms and Both Legs	The Full Amount
Both Arms	2/3 of the Amount
Both Legs	2/3 of the Amount
One Arm and One Leg	2/3 of the Amount
Both Arms and One Leg or Both Legs and One Arm	3/4 of the Amount
One Arm or One Leg	1/2 of the Amount

In order to be eligible for benefits for Total Loss of Use of limbs, such loss must continue for a period of twelve (12) consecutive months after the onset and must be shown by proper medical authority at the end of such twelve (12) months that Total Loss of Use has been continuous and will be permanent.

"Total Loss of Use" means the loss of the ability to function because of: (1) incurable paralysis; (2) atrophy; or (3) an arthritic condition resulting directly and independently of all other causes from an Injury. "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.

EXCLUSIONS

A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) to which sickness, disease (except ptomaine poisoning and infection which results from an accidental cut or wound) or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor ; or

(4) sustained during your participation in a felony; or

(5) to which your acute or chronic alcoholic intoxication is a contributing factor; or

(6) to which your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

SEAT BELT AND AIR BAG BENEFIT

Seat Belt Benefit

We will pay an additional Seat Belt Benefit if, due to an Injury sustained while driving or riding in a private passenger Four-Wheel Vehicle, you suffer loss of life for which an Accidental Death Benefit is payable under the Policy.

Once we receive the police accident report which confirms that you were properly strapped in a Seat Belt at the time of the accident, we will pay a benefit equal to 10% of the Accidental Death Benefit payable under the Policy.

If the police report does not clearly establish that you were or were not wearing a Seat Belt at the time of the accident which caused your death, the benefit payable will be $1,000 in lieu of the benefit described above.

"Seat Belt" means an unaltered factory-installed lap and/or shoulder restraint designed to keep a person steady in a seat.

Air Bag Benefit

In addition to the Seat Belt Benefit, we will also pay an Air Bag Benefit if such private passenger Four-Wheel Vehicle is equipped with a factory-installed Air Bag and the police accident report clearly establishes that you were positioned in a seat which is designed to be protected by an Air Bag and were properly strapped in the Seat Belt when the Air Bag inflated.

Once we receive the police accident report which confirms that the Air Bag inflated properly upon impact, we will pay a benefit equal to 5% of the Accidental Death Benefit payable under the Policy.

"Air Bag" means an unaltered factory-installed supplemental restraint system designed to inflate upon impact to protect a person from bodily Injury during an accident.

"Four-Wheel Vehicle" means a private passenger automobile, a truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less, or a self-propelled motor home, all of which are registered for private passenger use and designated for transportation on public roadways.

Maximum Benefit Payable – The total combined maximum benefit payable under the Seat Belt and Air Bag Benefit is $25,000.

EXCLUSIONS

No benefit is payable for any loss sustained by you:

(1) while participating as a professional in the sport of race car driving;

(2) if you were not wearing a Seat Belt for any reason;

(3) while you were sharing a Seat Belt; or

(4) due to a defect in the Air Bag diagnostic system.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 12 months after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Office or to our authorized agent. The notice should include the Policyholder's name, the Policy number and your name.

CLAIM FORMS: When we receive the notice of claim, we will send the claimant the forms to file the proof of loss. If we do not send them within 15 days after we receive notice, then the proof of loss requirements will be met by giving us a written statement of the nature and extent of the loss within 12 months after the loss began.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 12 months. If it is not reasonably possible to give proof within 12 months, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

First Reliance Standard Life shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have you examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years from the time written proof of loss is received.

EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage and that of any Insured Dependent, if applicable, not less than twelve (12) weeks in a twelve (12) month period in accordance with the Policyholder granting leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for you and your Insured Dependents, if applicable, continues to be paid by the Policyholder during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage and that of any Insured Dependents, if applicable, not less than twelve (12) weeks in a twelve (12) month period in accordance with the Policyholder's granting of Military Services Leave of Absence under USERRA if the premium for you and your Insured Dependents, if applicable, continues to be paid by the Policyholder during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while in the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority including: active duty, active or inactive duty for training, or full-time National Guard, if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder's granting of Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated in accordance with the Individual Reinstatement provision.

If coverage is terminated or reduces, you may convert such coverage in accordance with the Conversion Privilege. You are eligible to convert your coverage under the Conversion Privilege at any time during the Family and Medical Leave of Absence and/or Military Services Leave of Absence. Please see Conversion Privilege for the rules governing conversion rights.

PREMIUMS

PREMIUM RATE: The premium due will be the rate per $1,000 of benefit multiplied by the entire amount of benefit volume then in force. The Policyholder will furnish to you the premium rate on the Policy effective date and when it is changed. We have the right to change the premium rate:

(1) on any premium due date after the Policy is in force for twenty-four (24) months; or

(2) when the extent of coverage is changed by amendment.

We will not change the premium rate due to (1) above more than once in any twelve (12) month period. We will tell the Policyholder in writing at least 60 days before the date of a change due to (1) above.

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF ACCELERATED BENEFITS WILL REDUCE THE DEATH BENEFIT. ONLY THE INSURED HAS THE RIGHT TO ACCELERATE THE DEATH BENEFIT.

RECEIPT OF ACCELERATED DEATH BENEFITS MAY BE TAXABLE. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, the Insured should seek assistance from a qualified tax advisor.

RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), AND SUPPLEMENTAL SECURITY INCOME (SSI). Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, the Insured should consult with the appropriate social services agency concerning how receipt will affect his, his spouse's and/or his child(ren)'s eligibility for public assistance.

Attached to Group Policy Number: GL 165100
Issued to Group Policyholder: Port Jefferson UFSD

This Rider is attached to and made a part of the Policy shown above. Your Certificate is hereby amended, in consideration of the application for this Rider, by the addition of the following benefit. In this Rider, First Reliance Standard Life Insurance Company will be referred to as “we", “us", “our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured’s Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Policy.

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured, subject to all Certificate provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means the primary Insured and his/her insured Dependents, if any.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured’s illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 12 months.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if, while insured, he is Certified as Terminally Ill. In order for this benefit to be paid:

(1) the Insured must make a Written Request; and

(2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. If we agree to installment payments, we will make four quarterly payments. Each payment will equal 25% of the total Accelerated Benefit. Once the Accelerated Benefit has been paid for any Insured under this Rider, no additional Accelerated Benefit is payable under this Rider for that Insured.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

(1) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.

(2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced by an amount equal to the Accelerated Benefit paid to the Insured, as will the maximum Face Amount available under the Conversion Privilege. After this reduction as a result of payment of the Accelerated Benefit, any subsequent changes in the amount of insurance are subject to the Conversion Privilege as stated in the Policy to which this Rider is attached.

The payment of the Accelerated Benefit will have no effect on the premium payment requirements of the Policy.

MISSTATEMENT OF AGE OR SEX: The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

TERMINATION OF AN INDIVIDUAL'S COVERAGE UNDER THIS RIDER: The coverage of any Insured under this Rider will terminate on the first of the following:

(1) the date his coverage under the Policy terminates;

(2) the date of payment of the Accelerated Benefit for his Terminal Illness; or

(3) the date he attains age 75.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Policy terminates. It is subject to all the terms of the Policy not inconsistent herewith.

In witness whereof, we have caused this Rider to be signed by our Secretary.

Secretary

Claim Procedures

CLAIM PROCEDURES FOR CLAIMS FILED WITH
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER APRIL 1, 2018

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

First Reliance Standard Life Insurance Company
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-353-3986.

In the event of any *Adverse Benefit Determination* (defined below), the claimant (or their authorized representative) may appeal that *Adverse Benefit Determination* in accordance with the following procedures. This opportunity to appeal exists without regard to the applicability of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), 29 U.S.C. 1001 *et seq.*

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

A Claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

Disability Benefit Claims

A claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (defined below) to a claim for benefits; and
7. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of Adverse Benefit Determinations may be submitted in accordance with the following procedures to:

First Reliance Standard Life Insurance Company
Quality Review Unit
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination;
8. In deciding the appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an Adverse Benefit Determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits.

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of Adverse Benefit Determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (defined below) to a claim for benefits; and
7. The notification shall be provided in a Culturally and Linguistically Appropriate (defined above) manner.

REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (where applicable).

DEFINITIONS

The term "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "Culturally and Linguistically Appropriate Manner" means:

- Oral language services (such as telephone customer assistance hotline) that includes answering questions in any Applicable Non-English Language and providing assistance with filing claims and appeals in any Applicable Non-English Language must be provided;
- A notice in any Applicable Non-English Language must be provided upon request; and
- A statement prominently displayed in any Applicable Non-English Language clearly indicating how to access the language services provided must be included in the English versions of all notices.

The term "Applicable Non-English Language" means:
With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the United States Secretary of Health and Human Services.

The term "us" or "our" refers to First Reliance Standard Life Insurance Company.

The term "Relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "First Reliance Standard Life Insurance Company" means First Reliance Standard Life Insurance Company and/or its authorized claim administrators.

First Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Plan Arranged By:

J J STANIS AND COMPANY INC
377 Oak Street
Suite 406
Garden City, NY 11530
(516) 465-3900

FIRST RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Home Office: New York, New York

GL 165100 CLASS 4

Edition: 4/2022