PUBLIC SAFETY CANCER INSURANCE POLICY PROGRAM

ISSUED BY:
THE PUBLIC SAFETY CANCER INSURANCE POLICY PROGRAM ("THE PROGRAM")

AS ADMINISTERED BY:
THE BOARD OF TRUSTEES OF THE ARIZONA PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM ("SYSTEM"), AN AGENCY OF THE STATE OF ARIZONA, OR ITS DESIGNATED AGENT.

This Plan is issued pursuant to, and is governed by, Arizona Revised Statutes ("A.R.S.") §§ 38-641 to -645 (the "Enabling Legislation") and any amendments thereto, as well as the provisions of Title 38, Chapter 5, Article 4, A.R.S. and Title 12, Chapter 7, Article 2, A.R.S. and any other Arizona statute or common law rule applicable to actions involving public entities such as the Program. This Plan is not subject to Titles I and IV of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.

This Plan is issued to the Covered Member in consideration of payment of premiums by the Covered Member's employer or the Covered Member as provided in the Enabling Legislation.

The System agrees to pay benefits to the Covered Member in accordance with all the provisions of this Plan, including the attached schedule of benefits (the "Schedule") and any official authorized Riders attached.

Premiums are payable to the System or the System's designated agent in amounts determined by this Plan, the Program or as otherwise set forth in the Enabling Legislation. The first premium is due as provided in the Enabling Legislation. Future premiums are due thereafter as provided by the terms of this Plan or as otherwise specified in the Enabling Legislation.

EFFECTIVE DATE

EFFECTIVE DATE: This Plan and the insurance provided by it becomes effective 12:01 A.M. Mountain Time on the Effective Date shown on the Schedule or the beginning of the Plan Month following the date the Covered Member's employer or the Covered Member pays the first premium due on the Plan, whichever is later. The Effective Date of coverage is shown on the Schedule.

The provisions found on the following attached pages and official authorized Riders form a part of this Plan as if recited over the signatures shown below.

This Revised Plan is executed on the Effective Date at Phoenix, Arizona.

Scott McCarty
_____
Scott McCarty, Chairman

Michael F Townsend
_____
Mike Townsend, Administrator

Effective date of Revised Benefits: January 1, 2024 upon approval of the Board of Trustees

SCHEDULE OF BENEFITS

Benefits are determined by this Schedule, the advance reimbursement indemnity schedule, and the terms of this Plan.

BENEFITS PROVISION	AMOUNTS AND LIMITS
Cancer Intensive Care Benefit	
Daily Benefit Reimbursement not to exceed actual incurred expenses.	$ 500.00
Pharmacy Benefit	
Reimbursement not to exceed actual incurred expenses.	Subject to Overall Lifetime Maximum
Death Benefit	
Not subject to Lifetime maximum.	$ 10,000.00
Experimental Treatment Benefit	
Maximum Benefit Amount: Reimbursement not to exceed actual incurred expenses.	$ 5,000.00
Genomic and Genetic Testing Benefit	
Maximum Benefit Amount: Reimbursement not to exceed actual incurred expenses.	$ 15,000.00
Diagnosis of Cancer Benefit* (First Occurrence of Cancer, except skin cancer)	
First Cancer Diagnosis (not skin cancer).	$ 15,000.00
Second and subsequent New Cancer Diagnosis (not skin cancer).	$ 7,500.00
(*This will be reported as two-thirds non-taxable income and one-third taxable income until December 31, 2024. These amounts will be 100% non-taxable beginning January 1, 2025)	
Skin Cancer Diagnosis Benefit*	
Per Each positive diagnosis, up to seven (7) positive diagnoses	$500.00
(*This will be reported as two-thirds non-taxable income and one-third taxable income until December 31, 2024. These amounts will be 100% non-taxable beginning January 1, 2025)	
Lifetime Maximum Benefit, up to seven (7) diagnoses	$ 3,500.00

Home Hospice Care Benefit
Daily Benefit
Reimbursement not to exceed actual incurred expenses. $ 50.00

Hospice Care Benefit
Daily Benefit
Reimbursement not to exceed actual incurred expenses. $ 180.00

Hospital Confinement Daily Benefit
Daily Benefit
Reimbursement not to exceed actual incurred expenses. $ 200.00

Imaging, Radiation and Chemotherapy Benefit
Lifetime Maximum Amount for This Benefit:
Reimbursement not to exceed actual incurred expenses. $ 10,000.00

Skilled Nursing Facility Benefit
Daily Benefit
Reimbursement not to exceed actual incurred expenses. $ 40.00

Overall Lifetime Maximum Benefit under Plan: $ 100,000.00

PAYMENT PROCEDURES

Skin Cancer Diagnosis Benefit - The diagnosis payment only, no other funding unless other eligible costs are incurred.

Diagnosis of Cancer Benefit (not skin cancer) – First cancer diagnosis and subsequent cancer diagnosis, not skin cancer, the member will be paid two amounts. The diagnosis amount (first or subsequent amount) plus a $1,000 reimbursement indemnity payment, subject to the amounts and limits listed in the Schedule of Benefits, to provide funding for all qualifying costs, other than the diagnosis payment.

After the initial diagnosis and reimbursement payments are made, the member will receive the next level reimbursement indemnity amount according to the following advance reimbursement indemnity schedule, after providing documentation showing out of pocket costs that exceed the initial or prior reimbursement level.

In 2024 this payment is reported as taxable income for one-third of the total amount, and the Covered Member should receive a Form W2 for this benefit. The member's employer will make the taxable payment and PSPRS the non-taxable portion of the payment. Subsequent to 2024 payments will no longer be taxable and will be paid directly to the member by PSPRS.

Advance Reimbursement Schedule	
Incremental	Cumulative
$1,000	$1,000
$1,000	$2,000
$1,000	$3,000
$1,000	$4,000
$1,000	$5,000
$5,000	$10,000
$5,000	$15,000
$5,000	$20,000
$5,000	$25,000
$5,000	$30,000
$10,000	$40,000
$10,000	$50,000
$10,000	$60,000
$10,000	$70,000
$10,000	$80,000
$10,000	$90,000

The amounts paid in accordance with the advance reimbursement schedule are subject to the lifetime maximum of the plan. When a member reaches the lifetime maximum, the final amount paid for advance reimbursement will be the balance to reach the lifetime maximum and not according to the above schedule.

Transition for members continuing cancer treatment – PSPRS will work with members that have received a non-skin cancer diagnosis benefit prior to January 1, 2024, to implement the reimbursement indemnity process. Receipt of the next reimbursement request for this group will be processed to move the member into the appropriate level of the advance reimbursement indemnity schedule. After this catch-up payment, future payments will follow the reimbursement indemnity process.

Death Benefits - Death benefit payments are an indemnity payment not subject to the advance reimbursement indemnity schedule, and not subject to the lifetime maximum.

DEFINITIONS

When used in this Plan, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders. Unless otherwise specified herein, any terms used in this Plan that are specifically defined in the Enabling Legislation or A.R.S. § 38-841 et seq. shall have the meanings ascribed to such words in such legislation.

ADEQUATE PROOF means evidence sufficient to demonstrate a fact or the validity of a claim herein beyond a reasonable doubt.

CANCER means a disease manifested by the presence of a malignant neoplastic disorder characterized by:

(1) the uncontrolled growth and spread of malignant cells;
(2) the invasion of tissue;
(3) leukemia; or
(4) Hodgkin's disease.

Cancer must be positively diagnosed by a Physician certified by the American Board of Pathology to practice Pathologic Anatomy; or by an Osteopathic Pathologist (each, a "Certified Pathologist"). The diagnosis must be on the basis of:

(1) a microscopic examination of fixed tissues; or
(2) preparations from the hemic system.

Such diagnosis must be made while the Covered Member is alive or during post-mortem examination. The pathologist's judgment must be based solely on the criteria of malignancy accepted either by the:

(1) American Board of Pathology; or
(2) Osteopathic Board of Pathology.

Such diagnosis must be made after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The System will accept clinical evidence if it substantially documents the diagnosis of Cancer, provided a diagnosis cannot otherwise be made due to an inoperable condition.

CHEMOTHERAPY means a cancericidal chemical substance that is used for the purpose of modification or destruction of tissue invaded by Cancer.

CONFINED or CONFINEMENT means that the Covered Member is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. He or she must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician.

Confinement does not include Treatment received in the Outpatient department of the facility. Outpatient Treatment means service rendered for a period of less than 24 hours.

COVERED EXPENSES means expenses or other payments reimbursable as described in this Plan.

COVERED MEMBER means a person eligible for benefits under this Plan as specified herein and/or the Enabling Legislation

EXPERIMENTAL TREATMENT means:

(1) drugs or chemical substances as approved by the U.S. Food and Drug Administration for experimental use in the treatment of human Cancer including but not limited to off-label drug use, and expanded access and right-to-try programs, as described and approved by the FDA; and
(2) surgery or therapy endorsed by either the National Cancer Institute or the American Cancer Society for experimental studies. Included in such definitions are: (a) Chemotherapy or Immunotherapy using experimental drugs or chemicals; (b) Hyperthemia; and (c) Atomic Particle Therapy.

GENOMIC AND GENETIC TESTING

Genomic testing means a biopsy of the patient's tumor, whereby cancer cells are isolated and extracted from the biopsy sample, and the cancer cells' DNA is sequenced in the lab to scan the sequenced genetic

profile for abnormalities that dictate how the tumor functions. Gene-mapping tests are based on the treating physician's recommendation and may be appropriate for patients with rare, unusual or hard-to-treat cancers, and for patients whose tumors did not respond adequately to conventional therapies.

Genetic testing means testing to determine whether a gene mutation contributed to an existing cancer diagnosis, and whether a person is at a greater risk of developing the same cancer again or developing another type of cancer. After a person has been diagnosed with cancer, the physician tests a sample of cancer cells to look for certain gene changes to give information on a patient's outlook (prognosis) and help tell whether certain types of treatment might be useful. These tests are not the same as the tests used to find out about inherited cancer risk or the likelihood of developing a certain type of cancer (pre-cancer screening).

For purposes of this Plan, genomic and genetic testing coverage includes new technological advancements in the fields of genomic and genetic testing, including but not limited to molecular profiling. Such testing, as recommended by a trained physician, when performed post-cancer diagnosis assists with, among other things most appropriate treatments, and whether cancer has spread and effectiveness of cancer treatments.

HOME HOSPICE CARE means services, care or Treatment provided to a Covered Member in his or her home under the direction of a Physician according to a Hospice Care Program.

HOSPICE CARE means services, care or Treatment provided to a Covered Member in a Hospice under the direction of a Physician according to a Hospice Care Program.

HOSPICE means a facility other than the Covered Member's home or that of his or her friends or relatives that:

(1) provides a Hospice Care Program;
(2) is separated from any other facility; and
(3) fulfills any licensing requirements of the state or locality in which it operates.

HOSPICE CARE PROGRAM means a coordinated, interdisciplinary program for meeting the special needs of dying individuals and their families, by providing palliative and supportive medical, nursing and other health services during the illness and bereavement:

(1) to individuals who have no reasonable prospect of cure and are estimated by a physician to have a life expectancy of less than six months; and
(2) to the families of those individuals.

HOSPITAL means an institution which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and Treatment to the sick or injured on an in-patient basis for which a charge is made
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) The care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a Hospice, rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility. It is not a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any

ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

IMAGING means scanning imaging technology authorized and recommended by the treating Licensed Provider to treat and to assess the spread of cancer and efficacy of cancer treatment, including but not limited to ultrasound, Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) scans.

INCURRED EXPENSE means the amount that the Covered Member paid out of pocket for a service to a Licensed Provider, facility, or pharmacy.

LICENSED PROVIDER means Nurse, Physician, and other specialists licensed for the assessment and treatment of the Covered Member's cancer.

NURSE means a Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). He or she may not be the Covered Member or a member of his or her immediate family.

PHYSICIAN means a doctor of medicine or a doctor of osteopathy licensed by the state in which he or she is resident to practice medicine or osteopathy. He or she must be practicing within the scope of his or her license for the service or Treatment given. He or she may not be the Covered Member or a member of his or her immediate family.

PLAN means the instant contract issued to the Covered Member providing the benefits described.

PLAN MONTH means the period of time starting on the first day of the month and ending on the last day of the same month.

RADIATION means treatment for cancer involving radioactive energy to destroy cancer cells and their division.

Second and subsequent New Cancer Diagnosis means new diagnosis and treatment for unrelated to prior paid diagnosis of cancer.

SKILLED NURSING FACILITY means an institution which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, skilled Nursing Services under a Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise the Facility 24 hours a day; and
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or Treatment of mental diseases or disorders;
(5) home or facility for custodial or educational care; or a

(6) Hospice.

SKIN CANCER means a malignant neoplasm originating in the skin. Skin Cancer includes tumors arising from the epidermis, dermis and subcutaneous tissue, including basal cell carcinoma, squamous cell carcinoma, Melanocarcinoma in-situ, and Bowen's disease in-situ.

TREATMENT means medical and surgical care by a Licensed Provider, Nurse or Physician to detect, address, remedy, assuage or cure Cancer. This includes examination, diagnostic procedures, surgery (including pre- and post-operative care), prescribed medication, and the application of remedies and therapy. It does not include any diagnostic procedures or examinations performed to diagnose Cancer or to monitor a previous removal or remedy of Cancer, provided there is no positive diagnosis of Cancer or a recurrence of Cancer.

ELIGIBILITY AND EFFECTIVE DATE OF PLAN

All Covered Members who are active or retired members of the Public Safety Personnel Retirement System ("System") and serve (or have served) as firefighters and police officers regularly assigned to hazardous duty of the type normally expected of firefighters and police officers or correctional officers employed by the state department of corrections or the state department of juvenile corrections or a detention officer employed by a county, city or town if the department, county, city or town has voluntarily established a program and the corrections officer or detention officer voluntarily enrolled in the program and who, prior to their membership in the System, have not been medically treated for or diagnosed as having a Cancer for which they make claim under this Plan, are eligible for reimbursement of the Covered Expenses referenced in this Plan, subject to the reimbursement indemnity process as shown in the advance reimbursement indemnity schedule, and other limitations, exclusions and restrictions otherwise stated in said Plan.

1. Each Covered Member under the Public Safety Personnel Retirement System will become insured under this Plan at the beginning of the Plan Month following his or her employment with the Public Safety employer. CORP employees that voluntarily enroll in the program coverage will begin upon the employer's payment of the first premium due under this Plan or the Effective Date, whichever is later. The Effective Date of coverage is shown on the Schedule of Benefits.
2. If a Covered Member is confined for any condition in a Hospital or an institution which provides medical care and Treatment on the date the Covered Member hereunder would otherwise become effective, he or she will be insured the day following his or her formal discharge from the Hospital or institution.

3. Any increase in benefits hereunder will be subject to a new Effective Date of Coverage on the increased amount of benefit only.

4. A Corrections Officer will become insured under this Plan if the following criteria are met:

    a. The Covered Members' Employer has accepted to be part of the Cancer program and set up criteria for accepting member's payments under this plan.

    b. The Covered Member shall make an irrevocable election to participate and pay an annual amount to continue eligibility under this plan.

After retirement for each year of credited service accumulated, PSPRS Covered Members are eligible for five months of service based eligibility coverage under this Plan, in addition to actual time served in DROP, for free. Similarly, CORP members who voluntarily enroll and make premium payments during employment also are eligible for five months service based free Plan coverage for each year of credited service, and for actual time spent in reverse DROP.

A Covered Member receiving benefits under the Plan before retirement or diagnosed with cancer subsequent to retirement remains eligible under the program after the service-based eligibility free coverage period by making premium payments. Otherwise, when a Covered Member has used his or her allotted service-based eligibility coverage period, coverage under this Plan will terminate, as provided in the Enabling Legislation.

CANCER BENEFIT

Except as provided under Exclusions, the System will pay benefits according to the Schedule of Benefits for Cancer that manifests itself while the Covered Member is insured under the Plan and any attached, official authorized Riders. Benefit payments to the Covered Member will begin for Covered Expenses for related cancer diagnosis, treatment or care incurred up to 90 days before the date the first pathological diagnosis of Cancer is made. Except as otherwise specified herein, benefits are only payable hereunder to a Covered Member suffering from Cancer, and except as otherwise expressly stated herein, no benefits are provided in this Plan to a Covered Member's dependents, family, associates or relations.

If the Covered Member receives Treatment for Cancer but positive diagnosis of such Cancer is not made during his or her lifetime, the System will make payment to either his or her surviving spouse or designated beneficiary of any applicable benefits if positive diagnosis that the Covered Member suffered from Cancer is made after the Covered Member's death. The System will pay for Covered Expenses incurred up to 90 days before the date of diagnosis of Cancer by a Certified Pathologist.

CANCER INTENSIVE CARE BENEFIT

Upon receipt of Adequate Proof that a Covered Member is confined in an Intensive Care Unit for the Treatment of Cancer, the System will pay a benefit for each day of Confinement up to the maximum daily Benefit. The benefit payable is subject to the following conditions:

(1) the Covered Member is Hospital Confined;
(2) the Confinement must be caused by Cancer;
(3) the Confinement begins while coverage under the Plan is in force for the Covered Member; and
(4) the Covered Member incurs a Covered Expense.

The benefit payable for each day of Confinement is shown on the Schedule of Benefits. This benefit is paid in lieu of the Hospital Confinement Benefit.

Intensive Care Unit means a facility in a Hospital other than the patient's bedroom or an operating or a recovery room. It must be designated by the Hospital as a department providing the highest level of Intensive Care.

DEATH BENEFIT

Upon receipt of Adequate Proof of death of a Covered Member as a result of Cancer while coverage is in force under the Plan, the System will pay the Death Benefit shown on the Schedule. This benefit is not subject to the Overall Lifetime Maximum Benefit amount.

DIAGNOSIS OF CANCER BENEFIT

Upon receipt of Adequate Proof that, after coverage has been in force for 30 days, a Covered Member is diagnosed for the first time as having Cancer, the System will pay a lump sum Benefit as shown on the Schedule. In 2024 this payment is reported as taxable income for one-third of the total amount, and the

Covered Member will receive a Form W2 for this benefit. The member's employer will make the taxable payment and PSPRS the non-taxable portion of the payment. Diagnosis payments amounts will be 100% non-taxable beginning January 1, 2025.

The Diagnosis of Cancer benefit is payable for a second and subsequent new cancer diagnoses, if unrelated to prior paid Diagnosis of Cancer benefit.. The Diagnosis of Cancer Benefit is subject to Overall Lifetime Maximum Benefit amount.

THE DIAGNOSIS OF CANCER BENEFIT IS NOT PAYABLE FOR DIAGNOSIS OF SKIN CANCER – see "SKIN CANCER BENEFIT" below.

EXPERIMENTAL TREATMENT BENEFIT

Upon receipt of Adequate Proof that a Covered Member incurs expenses for an experimental treatment as defined in this document, the System will pay the charges for such treatment not to exceed the Maximum Benefit shown on the Schedule.

GENOMIC AND GENETIC TESTING BENEFIT

Upon receipt of Adequate Proof that a Covered Member incurs expenses for Genomic and/or Genetic Testing post-cancer diagnosis, the System will pay the benefit for such testing not to exceed the Maximum Benefit shown on the Schedule.

HOME HOSPICE CARE BENEFIT

Upon receipt of Adequate Proof that a Covered Member receives Home Hospice Care, the System will pay for actual expenses incurred by the Covered Member up to the amount shown in the Schedule of Benefits. The benefit is subject to the following conditions:

(1) a Physician certifies that the Covered Member has Cancer for which there is no reasonable prospect of cure and that life expectancy is less than six months;
(2) the Home Hospice Care follows a Hospital, Hospice Care Facility or Skilled Nursing Facility Confinement of at least 3 consecutive days for which benefits are payable under the Plan; and
(3) the Home Hospice Care must be received while coverage under the Plan is in force for the Covered Member.

HOSPICE CARE BENEFIT

Upon receipt of Adequate Proof that a Covered Member receives Hospice Care, the System will pay the amount shown on the Schedule for actual expenses incurred by the Covered Member up to the amount shown in the Schedule of Benefits.

HOSPITAL CONFINEMENT DAILY BENEFIT

The System will pay the Hospital Confinement Daily Benefit for Cancer Treatment provided the Covered

Member is Hospital Confined. Upon receipt of Adequate Proof that a Covered Member is Hospital Confined for the Treatment of Cancer, the System will pay for actual expenses incurred by the Covered Member up to the amount shown in the Schedule of Benefits for each day of Confinement. The benefit is subject to the Overall Lifetime Maximum Benefit amount. This benefit is not payable if the Confinement is payable or paid under the Cancer Intensive Care Benefit.

PHARMACY BENEFIT

Upon receipt of proof of prescribed medications, submitted by Covered Members Physician for their treatment of Cancer, the System will reimburse only the Covered Member for actual incurred expenses for medications as prescribed and identified by the treating physician(s).

IMAGING, RADIATION AND CHEMOTHERAPY BENEFIT

Upon receipt of Adequate Proof that the Covered Member incurred expenses for the cost of imaging technology, x-ray, radiation therapy (including radium or cobalt), or chemotherapy Treatments, the System will pay a benefit for these expenses not to exceed the Maximum Benefit shown on the Schedule. Eligible expenses for this Benefit include Treatments incurred while Hospital Confined, as an outpatient or in a free standing facility.

SKILLED NURSING FACILITY BENEFIT

Upon receipt of Adequate Proof that a Covered Member, following a covered Hospital Confinement which lasted at least 3 consecutive days, incurs Covered Expenses for Treatment in a Skilled Nursing Facility, the System will pay for actual expenses incurred by the Covered Member up to the amount shown in the Schedule of Benefits.

SKIN CANCER BENEFIT

Upon receipt of Adequate Proof that a Covered Member has received a positive diagnosis of Skin Cancer, the Plan shall pay a benefit per the Schedule of Benefits. This payment shall be made for each such first diagnosis up to the Lifetime Maximum as shown in the Schedule of Benefits. This will be reported as two-thirds non-taxable income and one-third taxable income until December 31, 2024. These amounts will be 100% non-taxable beginning January 1, 2025.

The lifetime maximum amount of this Skin Cancer Benefit is $3,500.

OVERALL MAXIMUM LIFETIME BENEFIT UNDER PLAN

Notwithstanding anything in this Plan to the Contrary, no Covered Member is or shall be entitled to benefits under this Plan in excess of One Hundred Thousand Dollars ($100,000.00). In other words, with the exception of the Death Benefit, once a Covered Member has received $100,000.00 in benefits under this Plan, the Covered Member's entitlement to further benefits under this Plan shall be exhausted and he or she shall be entitled to no further benefits under the Plan.

EXCLUSIONS

Benefits will not be paid under the Plan and any official, authorized Rider for any Covered Expenses which arise or result from:

(1) injury or sickness other than Cancer;
(2) Pre-Existing Conditions, which are defined as a Cancer in the Covered Member that was positively diagnosed prior to the Covered Member's membership in the Public Safety Personnel Retirement System. A Covered Member is not eligible for benefits under this Plan if there is any evidence that the Cancer that forms the basis of the Covered Member's claim under the Plan existed before the Covered Member's date of membership in the Public Safety Personnel Retirement System or the Corrections Officer Retirement Plan.

WHEN COVERAGE ENDS

The Covered Member's coverage under this Plan automatically ends on the first of the following dates:

(1) The date the Plan is terminated;
(2) The premium due date the Covered Member's employer fails to pay the required premium, except as provided in the Grace Period; or
(3) The Covered Member has exhausted his or her benefits or his or her employment is terminated as provided in A.R.S. § 38-644.

EXTENSION OF BENEFITS

If the Covered Member's coverage under this Plan terminates for any reason, except non-payment of premium, and prior to termination he or she incurs Covered Expenses, he or she will receive payments for the duration of any Hospital Confinement just as if coverage had not ended provided any Confinement starts within 90 days after the termination date, and Confinement is due to the same Cancer for which he or she incurred Covered Expenses before this termination date.

No additional premium is needed for the extended benefit payments after termination of coverage.

PREMIUMS

The System provides coverage for Covered Members in return for premium payment. Premiums are payable by the Covered Member's employer when the Covered Member is an active firefighter or a peace officer, and premiums are paid by the Covered Member when the Covered Member is an active corrections officer or a retiree that is eligible for extended coverage as specified in the Enabling Legislation. The first premium is due as specified in the Enabling Legislation. Premiums are paid to the System on or before the due date. The initial premium rates are specified in the Enabling Legislation, and premiums may be increased or decreased as specified in the Enabling Legislation.

PREMIUM CHANGES. The System has the right to change the premium rates on any premium due date, so long as such change is authorized in the Enabling Legislation, as amended. The System will provide the Covered Member or the Covered Member's employer written notice at least 31 days before the date of change. The premium rates may also be changed at any time the terms of the Plan are changed. Premiums must be paid as specified in the Enabling Legislation.

GRACE PERIOD. The Covered Member's employer or the Covered Member has a 60-day grace period (the "Grace Period") for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. At the System's election, coverage under this Plan will end at the end of the Grace Period if all premiums which are due are not paid. The System will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

REINSTATEMENT OF COVERAGE. If the System terminates coverage under this Plan for non-payment of premium, the Covered Member may reinstate coverage within 90 days following the last unpaid premium due date. To reinstate the Covered Member's coverage under this Plan, the delinquent premiums must be paid in full. When the Covered Member is an active firefighter or peace officer, the employer must pay the System all overdue premiums and any additional charges as specified in the Enabling Legislation. When the Covered Member is an active corrections officer, the Covered Member must pay all overdue premiums through their employer. When the Covered Member is a retiree, the retiree must pay us all overdue premiums before reinstatement is granted.

GENERAL PROVISIONS

CHOICE OF PHYSICIAN. The Covered Member is free to be treated by any Physician of his or her choice, including Physicians, clinics or providers situated outside the United States.

CLERICAL ERROR. Clerical errors or delays in keeping records for this Plan will not deny benefits which would otherwise have been granted, nor extend benefits which otherwise would have ceased.

CONFORMITY WITH LAW. Any provision of this Plan in conflict with the laws of the State of Arizona is amended to conform with the laws of said State.

ENTIRE CONTRACT; CHANGES. This Plan and the Enabling Legislation and other statutes and laws referenced therein, as well as any other attachments and Riders to the Plan are the entire contract between the Covered Member and the Program. This Plan may be changed by the System at any time, **and you have no vested right to benefits hereunder until such time as you have first suffered or incurred a Cancer giving rise to a covered claim to benefits hereunder**.

NONPARTICIPATING. This Plan is a nonparticipating Plan, which means that the Covered Member does not share in any surplus funds held by the Program.

WORKERS' COMPENSATION. This Plan is not a Worker's Compensation plan of insurance. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

WHEN THERE IS A CLAIM

SUBMISSION OF CLAIMS. Claims under this Plan should be provided as soon as reasonably possible by the Covered Member. Claims covered under this Plan will not be valid or payable if the claim is not tendered to the System within 24 months of the date the claim was incurred. If the claim is for the "Diagnosis of Cancer" benefit or the "Skin Cancer Benefit", the System must receive notification of that claim within 24 months of when member is positively diagnosed for Cancer for the first time. Claims submitted beyond 24 months will be reviewed for payment on a case-by-case basis. Claims may be submitted on behalf of

the Covered Member by an authorized power of attorney or legal designee. The submission of a "Diagnosis of Cancer" or a "Skin Cancer Benefit" claim must include:

- a completed Initial Claim Form,
- a completed Attending Physician Form, which must include the "List of Prescribed Medications", and
- the pathology report that shows the Cancer diagnosis.

Additional covered benefits as outlined in the Schedule of Benefits should be submitted with the applicable claim form and adequate proof of the claim.

Adequate Proof includes an explanation of benefits ("EOB") from any insurance carrier or carriers that have paid benefits on your behalf for the claim and an itemized bill from the healthcare providers that clearly indicates the members out of pocket expenses.

Claims may be mailed to the System at P. O. Box 17323, Phoenix, Arizona, 85011 attn: PUBLIC SAFETY CANCER INSURANCE POLICY PROGRAM or faxed to 602-296-2371 and emailed to cancerins@psprs.com.

PAYMENT OF CLAIMS. Claims for benefits provided by the Plan will be paid within a reasonable period following the System's determination (or that of our agent) that the Covered Member has provided the System with Adequate Proof of the validity of such claim. The System will make taxable benefits to the member's employer for payment to the Covered Member.

Claims shall not be eligible for double payment, including under separate listed Benefits in the Plan, for any Schedule of Benefits payment is limited to actual incurred expenses, subject to the Advance Reimbursement Schedule.

All benefits are paid directly to the Covered Member. If a benefit is unpaid at a Covered Member's death, the System will pay either his or her surviving spouse or designated beneficiary. Any payment the System makes in good faith will fully discharge the System to the extent of the payment. Any party who contests such payment on grounds he or she is entitled to same under this Plan shall be obligated to reimburse the System for all attorneys' fees and all costs of litigation reasonably incurred by the System to defend the propriety of such payment if it is determined in a court of appropriate jurisdiction that the System's payment was appropriate.

When a claim is paid for expenses incurred during the Grace Period, any premium due and unpaid the System may be deducted from the claim payment. If the Covered Member's employer is responsible for the premium, the Covered Member may seek reimbursement for the deducted sums from his or her employer.

RIGHT TO RECOVERY. If payments for claims exceed the maximum amount payable under any benefit provisions or official, authorized Riders of the Plan, the System have the right to recover the excess of such payments from the Covered Member using any lawful means, including, without limitation, offsetting the amounts overpaid by any amounts payable to the Covered Member under this Plan.

PHYSICAL EXAMINATION AND AUTOPSY. At the System's expense, the System has the right to have the Covered Member examined as often as necessary while a claim by that Covered Member is pending. At the System's expense, the System may require an autopsy of a deceased Covered Member.

LEGAL ACTIONS. No legal action may be brought by a Covered Member to recover against the Program or Plan until the Covered Member has submitted to the System all written documentation he or she believes to support his or her claim and at least 60 days have transpired since such submission to enable the System (or designated agent) sufficient time to evaluate the claim. No legal action may be brought against the System or the Program by a Covered Member more than one year from the time the System disapproves all or a portion of the Covered Member's claim. All provisions of law concerning the defenses inuring to a public entity like the Program and its Administrator (and its employees, attorneys and agents) are expressly incorporated into and made a part of this Plan, and a Covered Member must strictly comply with same.

ATTORNEYS' FEES. The prevailing party in any litigation concerning this Plan shall be awarded its reasonable attorneys' fees and all costs of litigation against the non-prevailing party, such an award to be made by a judge and not a jury. If the Program and/or its Administrator (or their employees, attorneys or agents) [collectively, "Program"] are awarded attorneys' fees and costs against a Covered Member, the Program may satisfy such fee and cost award from any amounts otherwise owing the Covered Member under this Plan, or through any other lawful means.

NO PUNITIVE DAMAGES. A Covered Member is not entitled to seek punitive damages against the Program, a public entity.

VENUE AND APPLICABLE LAW. Any and all legal action brought against the Program and its Administrator shall be brought in the Maricopa County, Arizona Superior Court. This Plan shall be governed by and construed under and pursuant to the laws of the State of Arizona, without regard to conflicts of law principles.

QUESTIONS. Questions about benefits, payments or eligibility should be made in writing and either mailed to P.O. Box 17323, Phoenix, AZ 85011 or faxed to 602-296-2371.