FIREFIGHTER CANCER INSURANCE POLICY

Underwritten by:
AXIS INSURANCE COMPANY
(A Stock Company)
(Herein called the Company)

For inquiries, information about coverage or for assistance in resolving complaints:
Please dial the Florida Consumer Helpline at:
1-877-MY-FL-CFO (1-877-693-5236)
TDD line: 1-800-640-0886
Out of State: (850) 413-3089

Administrative Office:	Home Office:
1 University Square Drive, Suite 200	111 South Wacker Drive, Suite 3500
Princeton, NJ 08540	Chicago, IL 60606

The Company will pay the benefits of this Policy subject to its provisions. This page and the pages that follow are part of this Policy.

AXIS Insurance Company insures the members of:
St. Johns County Board of County Commissioners (the Policyholder**)**

Policy Number: **PRCA-97333-FL10044**

AXIS Insurance Company (referred to as the Company, We, Our, or Us) will pay the benefits provided by this Policy in return for the advance payment of premium. AXIS Insurance Company makes this promise subject to all of this Policy's provisions.

The Policy is a legal contract between the Policyholder and the Company.

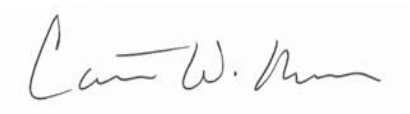
This Policy is issued in and governed by the laws of Florida. This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date at the Policyholder's address. It will remain in effect for the duration of the Policy Term if the premium is paid according to the agreed terms. This Policy terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term.

The Company and the Policyholder agree to all the terms of this Policy.

10 Day right to examine this Policy – The Policyholder should read this Policy carefully and contact us promptly with any questions. If the Policyholder is not satisfied for any reason, this Policy may be returned within 10 days of its receipt. We will refund any premiums already paid within 10 days after the Company receives the Policyholder's notice of cancellation of this Policy, and it will be considered never to have been issued.

The President and Secretary of the Company witness this Policy.

Secretary



President

THIS IS A LIMITED POLICY.
IT PAYS BENEFITS ONLY FOR SPECIFIC LOSSES FROM CANCER.
READ IT CAREFULLY.

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POLICY SCHEDULE

Policyholder:	**St. Johns County Board of County Commissioners**		
Policy Number:	**PRCA-97333-FL10044**	**Policy Effective Date:**	**10/01/2022**
Renewal Date:	**10/01/2023**	**Expiration Date:**	**09/30/2023**
Payment Method:	**1 Year Annual**	**Total Premium:**	**$59,938.60**
Premium Due Date:	**10/01/2022**	**Policy Term:**	**10/01/2022 - 09/30/2023**
Rate Guarantee Period:	1 year		
The initial premium rate guarantee and any premium rate guarantee applicable to renewal are subject to the Policy Term and Renewal and Premium Rate Change sections of this Policy.			

Named Insured(s):	City of St. Augustine	
Eligible Persons:		
Class 1	An active full-time Firefighter (as defined in this Policy)	Coverage Effective Date: the Policy Effective Date or the date on which the Eligible Person meets the Class 1 requirements whichever is later
Class 2	After having qualified as a Firefighter in Class 1, a Firefighter whose employment has terminated shall remain eligible for 10 years following the date on which the Firefighter terminates employment	Coverage Effective Date: the Policy Effective Date or the date on which the Eligible Person ceases to be a member of Class 1 and meets the Class 2 requirements whichever is later

If an Insured Person is eligible under Class 1 and later becomes eligible under Class 2, changes in His insurance due to the class change will be effective on the date of the change in class.

POLICY SCHEDULE OF BENEFITS

This Policy provides coverage for the following Line of Duty Cancer benefits:

Line of Duty Cancer Initial Diagnosis Benefit*
Benefit Amount $25,000 (Lump Sum)

Line of Duty Cancer Diagnosis Lifetime Maximum $50,000

*This benefit is an alternative to pursuing workers' compensation benefits under chapter 440

Line of Duty Cancer Death Benefit - Class 1 Only
Benefit Amount $75,000

This benefit is an alternative to pursuing workers' compensation benefits under chapter 440

DEFINITIONS

Company means AXIS Insurance Company**.**

Coverage Effective Date means the date shown on the *Policy Schedule.*

Diagnosed/Diagnosis – means a definitive and unequivocal diagnosis identifiable by a code under the most current ICD code structure made by a Physician who specializes in the condition for which benefits are being claimed:

1. based upon the use of clinical and/or laboratory investigations as supported by the Insured Person's medical records; and
2. meeting any Diagnostic Requirements set forth in this Policy for Line of Duty Cancer. The disease or infirmity shall be presumed to have been caused by or to have resulted from the work performed. This presumption shall be rebuttable by evidence meeting judicial standards.

Employer means a state board, commission, department, division, bureau or agency, or a county, municipality, or other political subdivision of the state.

Firefighter means an individual employed as a full-time firefighter within the fire department or public safety department of an Employer whose primary responsibilities are the prevention and extinguishing of fires; the protection of life and property; and the enforcement of municipal, county, and state fire prevention codes and laws pertaining to the prevention and control of fires.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, domestic partner, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), child (includes legally adopted or stepchild), grandparent, grandchild, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother-in-law, or father-in-law.

Insured Person means a person in an Eligible Class, as defined on the *Policy Schedule,* for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Line of Duty Cancer means:

1. Bladder cancer.
2. Brain cancer.
3. Breast cancer.
4. Cervical cancer.
5. Colon cancer.
6. Esophageal cancer.
7. Invasive skin cancer.
8. Kidney cancer.
9. Large intestinal cancer.
10. Lung cancer.
11. Malignant melanoma.
12. Mesothelioma.
13. Multiple myeloma.
14. Non-Hodgkin's lymphoma.
15. Oral cavity and pharynx cancer.
16. Ovarian cancer.
17. Prostate cancer.
18. Rectal cancer.
19. Stomach cancer.
20. Testicular cancer.
21. Thyroid cancer.

Medically Necessary means medical services that:

1. are essential for Diagnosis, treatment or care of the Line of Duty Cancer for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. are ordered by a Physician and performed under his or her care, supervision or order.

Named Insured means any organization listed on the *Policy Schedule.*

Physician means a licensed health care provider practicing within the scope of his or her license and rendering care and treatment to the Insured Person that is appropriate for the condition and locality, and who is not:

1. the Insured Person;
2. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
3. a person living in the Insured Person's household;
4. a person employed or retained by the Employer; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policy Effective Date means the date the Policy takes effect for the Policyholder.

Policy Term means the time period defined for the Policyholder shown on the *Policy Schedule.*

Policyholder means the Employer named on the *Policy Schedule***.** This includes additional organizations identified by endorsement attached to the Policy.

Spouse means the Insured Person's lawful Spouse. The term Spouse will include domestic partner.

BENEFITS

LINE OF DUTY CANCER INITIAL DIAGNOSIS BENEFIT

If, while coverage under this Policy is in force, an Insured Person is Diagnosed with Line of Duty Cancer, by a Physician in the medical specialty appropriate for the type of cancer Diagnosed, the Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits* subject to the Lifetime Maximum Benefit, Diagnostic Requirements and Benefit Payment Conditions.

Once a Line of Duty Cancer has been so Diagnosed and an Initial Diagnosis Benefit has become payable to an Insured Person, no benefits are payable to that Insured Person with respect to a subsequently Diagnosed recurrence of the same Line of Duty Cancer or a subsequently Diagnosed separate Line of Duty Cancer.

Diagnostic Requirements

The Company reserves the right to have any Line of Duty Cancer Diagnosis reviewed by a Physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to request an examination of either the Insured Person or the evidence used in arriving at such Diagnosis by an independently acknowledged expert selected by the Company in the applicable field of medicine.

The Line of Duty Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.

The opinion of such expert as to such Diagnosis shall be binding on both the Insured Person and the Company.

Benefit Payment Conditions

Payment of benefits upon the Diagnosis of Line of Duty Cancer is subject to:

1. the Diagnosis is made while the Insured Person's coverage is in force under the Policy;
2. the Insured Person has been employed as a Firefighter with the Employer for at least five (5) continuous years;
3. the Insured Person has not used tobacco products for at least five (5) years preceding Diagnosis; and
4. the Insured Person has not been employed in any other position in the five (5) years preceding Diagnosis which is proven to create a higher risk for any cancer.

No benefits will be payable for:

1. any disease, sickness or incapacity other than Line of Duty Cancer as defined; this is so even though such disease, sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Line of Duty Cancer;
2. any Line of Duty Cancer Diagnosis that occurs prior to the Policy Effective date;
3. any Line of Duty Cancer Diagnosis that occurs prior to the Insured Person's Coverage Effective Date;
4. any Line of Duty Cancer Diagnosis occurring after the Policy terminates;
5. any Line of Duty Cancer Diagnosis occurring after the Insured Person's coverage terminates.

Termination of Employment

If an Insured Person terminates employment with the Employer, the Line of Duty Cancer Initial Diagnosis Benefit is payable upon Diagnosis of Line of Duty Cancer for 10 years following the date on which the Firefighter terminates his or her employment. The Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits* subject to the Lifetime Maximum Benefit, Diagnostic Requirements and Benefit Payment Conditions.

Benefit Payment Conditions

After termination of employment, payment of benefits upon the Diagnosis of Line of Duty Cancer is subject to:

1. the Diagnosis is made while the Insured Person's coverage is in force under the Policy;
2. after termination of employment, the Insured Person continued coverage in the Employer-sponsored health plan or Employer-sponsored group health insurance trust fund;
3. after termination of employment, the Insured Person was not subsequently employed as a Firefighter;
4. prior to termination of employment, the Insured Person was employed as a Firefighter with the Employer for at least five (5) continuous years;

5. the Insured Person has not used tobacco products for at least five (5) years preceding Diagnosis; and
6. the Insured Person has not been employed in any other position in the five (5) years preceding Diagnosis which is proven to create a higher risk for any cancer.

No benefits will be payable for:

1. any disease, sickness or incapacity other than Line of Duty Cancer as defined; this is so even though such disease, sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Line of Duty Cancer;
2. any Line of Duty Cancer Diagnosis that occurs prior to the Policy Effective date;
3. any Line of Duty Cancer Diagnosis that occurs prior to the Insured Person's Coverage Effective Date;
4. any Line of Duty Cancer Diagnosis occurring after the Policy terminates;
5. any Line of Duty Cancer Diagnosis occurring after the Insured Person's coverage terminates.

An Insured Person is not eligible for benefits under this policy if the Insured Person is already paid workers' compensation benefits under chapter 440.

LINE OF DUTY CANCER DEATH BENEFIT - CLASS 1 ONLY

If, while coverage under this Policy is in force, an Insured Person dies as a result of Line of Duty Cancer or from circumstances that arise out of the treatment of Line of Duty Cancer, the Company will pay the Benefit Amount shown on the *Policy Schedule of Benefits*, subject to the Benefit Payment Conditions.

Benefit Payment Conditions

Payment of Line of Duty Cancer Death Benefit is subject to the following:

1. the death must occur while the Insured Person's coverage is in force under the Policy; and
2. acceptable proof must be provided to the Company, or its authorized claims payor, that such death was a result of Line of Duty Cancer or circumstances that arise out of the treatment of the Line of Duty Cancer.

No benefits will be payable for:

1. any death that occurs due to any disease, sickness or incapacity other than Line of Duty Cancer as defined herein; even though such disease, sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Line of Duty Cancer;
2. any Line of Duty Cancer death that occurs prior to the Policy Effective Date;
3. any Line of Duty Cancer death that occurs prior to the Insured Person's Coverage Effective Date;
4. any Line of Duty Cancer death occurring after the Policy terminates; or
5. any Line of Duty Cancer death occurring after the Insured Person's coverage terminates.

CLAIMS PROVISIONS

CLAIM FORMS

Our administrator will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the Company received notice of claim, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made. The notice should include the Insured Person's name, the Policyholder name and the Policy number. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

NOTICE OF CLAIM

Written notice of claim must be given to Our administrator within 20 days after the Diagnosis of the Insured Person's covered Line of Duty Cancer or as soon thereafter as reasonably possible but in no event more than a year (12 months) after first knowledge of the Line of Duty Cancer. Notice given by or on behalf of the claimant to the Company or to its designated authorized agent, with information sufficient to identify the Insured Person, is deemed notice to the Company. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form.

PROOF OF LOSS

Written proof of loss must be sent to Us or Our authorized representative. Written proof must be given within 120 days after the date of loss. Failure to furnish such proof within such time will not invalidate or reduce any claim if it can be shown not to have been reasonably possible to furnish such proof within such time, provided proof was furnished as soon as reasonably possible. If We require additional information in order to make a claim determination, We shall provide written notice to the claimant. The additional information must be provided within 45 days from the date of the request.

The Insured Person is responsible for providing all necessary information to substantiate the validity of their claim. Any forms that may be required to be provided under this subsection may be provided in electronic or paper form.

TIME OF PAYMENT OF CLAIMS

All benefits will be paid in United States currency. After We received written proof of loss of time due to disability, disability benefits payable under the Policy for loss of time will be paid monthly during the continuance of the period for which the Company is liable. Benefits for any other loss covered by this Policy will be paid as soon as We receive proper proof of loss. We will reimburse all claims or any portion of any claim from the Insured Person or the Insured Person's assignee within 45 days after receipt of the claim. If We contest a claim or any portion of a claim, We will notify the Insured Person or the Insured Person's assignee in writing which identifies the contested portion of the claim and the reasons for contesting it. This notice will be sent within 45 days after receipt of the claim. Upon Our receipt of additional information requested from the Insured Person or the Insured Person's assignees, We will pay or deny the contested claim or portion of the contest claim within 60 days. All claims will be paid or denied no later than 120 days after Our receipt of the claim. Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the US mail in a properly addressed, postpaid envelope or, if not posted, on the date of delivery. Any overdue payments will include interest at the rate of 10% per year. Upon written notification by an Insured Person, We will investigate any claim of improper billing by a physician, hospital, or other health care provider. We will determine if the Insured Person was properly billed for only those procedures and services that were actually received. If We determine that the Insured Person has been improperly billed, We will notify the Insured Person and the provider of Our findings and reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured Person, We will pay to the Insured Person 20% of the amount of the reduction up to $500.

PAYMENT OF CLAIMS

In consideration of the Policyholder's payment of the entire premium, the Policyholder shall be the Insured Person's assignee under the Policy.

PAYMENT OF LOSS OF LIFE CLAIMS

Upon receipt of due written proof of Line of Duty Cancer Death, benefits for a loss of life claim will be paid to the beneficiary named by an Insured Person when he or she or she became covered under this Policy. An Insured Person has the right to change his or her beneficiary at any time by completing a form, approved by us, and submitting it to the Policyholder. The new beneficiary designation will be effective as of the date an Insured Person

signed the required form. However, if We have taken any action or made any claim payment before the Policyholder receives an Insured Person's request to change his or her beneficiary, that change will not go into effect.

If an Insured Person does not name a beneficiary or names more than one beneficiary but does not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured Person, or the share of a beneficiary who is disqualified will pass to any surviving beneficiaries in the order designated by an Insured Person.

If an Insured Person does not name a beneficiary, or if a named beneficiary is disqualified, or if all named beneficiaries die before an Insured Person, We have the option of paying death benefits to an Insured Person's estate or surviving family members in the order listed below:

1. Spouse, domestic partner, partner in a civil union;
2. child or children, equally if living, otherwise to their descendants per stirpes;
3. mother or father, equally or to the survivor; or
4. sisters or brothers, equally or to the survivor or survivors.

COOPERATION OF THE INSURED PERSON

Coverage under this Policy may terminate for any Insured Person who fails to cooperate with the Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

RIGHT TO OFFSET

If We determine that an overpayment of any benefit payable under this Policy has been made to an Insured Person due to fraud or any error We make in processing a claim, We reserve the right to:

1. offset said overpayment against any amounts otherwise payable to an Insured Person;
2. request reimbursement from an Insured Person for any overpayment made; or
3. bring legal action against an Insured Person to recover any overpayment.

PHYSICAL EXAMINATION

We, at Our expense, have the right to have an Insured Person examined as often as is reasonable while a claim is pending. We may also request to have an Insured Person examined, at Our expense, as proof of continued loss. We reserve the right to select the examiner.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after the required proof of loss is furnished in accordance with the terms of this Policy. No action shall be brought at all unless brought within the applicable statute of limitations from the time within which proof of loss is required to be given.

ARBITRATION

Any controversy or claim, or any breach of contract, arising out of or relating to this Policy shall, upon express written agreement by both parties to this Policy, be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the Insured Person or person claiming to be the beneficiary. The arbitrators(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the Insured Person or the person claiming to be the beneficiary is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if this Policy is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of any individual or class action lawsuit brought by the Insured Person, his or her legal representatives, or beneficiary.

PREMIUMS AND RENEWALS PROVISIONS

POLICY TERM AND RENEWAL

The first term of this Policy starts on the Effective Date shown on the *Policy Schedule of Benefits* and ends on the Expiration Date, also shown on the *Policy Schedule of Benefits*. The Policy will remain in effect for the duration of the Policy Term if the premium is paid according to the agreed upon terms. Later terms will be the periods for which the Policyholder pays renewal premiums agreed upon when due. All terms will begin and end at 12:01 A.M., Standard Time, at the location of the Policyholder.

The Company may terminate this Policy on any anniversary of the first Renewal Date by giving the other party written notice at least sixty (60) days prior to that date. The Company is not required to provide such notice if cancellation is due to nonpayment of premiums. The Policyholder may terminate this Policy on any anniversary of the first Renewal Date by giving the other party written notice at least sixty (60) days prior to that date. In these events, this Policy will terminate on the specified anniversary date at 12:01 A.M., Standard Time. Any premium rate guarantee will not affect the Company's or the Policyholder's right to terminate this Policy. Termination or nonrenewal will be without prejudice to the rights of any Insured Person with respect to any benefits payable under this Policy that began while this Policy was in force.

PREMIUMS

Premiums are paid at the Company's Home Office or to the Company's authorized agent. Any premium remitted by the Policyholder to its agent or broker will not be considered paid until it is received by us at Our office. If any premium is not paid when due, this Policy will be cancelled at the end of the last period for which premium was paid, except as provided in the Grace Period provision.

The first premium is due on the Effective Date shown on the *Policy Schedule of Benefits*. The renewal premium for each term will be due on the day the preceding term ends, subject to the Grace Period**,** unless the Policyholder and the Company agree to another mode of premium payment.

We may change the premium rate on any Renewal Date of this Policy or whenever the terms or conditions of the Policy are changed.

PREMIUM RATE CHANGES

After the initial twelve months of coverage the Company may change premium rates at the end of any Policy Term with at least sixty (60) days prior advance written notice mailed to the last known address of the Policyholder. The Company will not increase premium rates during the initial twelve (12) months of coverage and, following the initial twelve (12) month period, not more than once in any six (6) month period, unless one of the events described below occurs.
The Company may change the premium rate during a Policy Term if any one of the following occurs:

1. the terms of this Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period;
3. a change in Insured Persons or Eligible Person's to be covered which would, on a manual rate basis, require a change of 25% or more in the premium rate;
4. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under this Policy; or
5. the Policyholder fails to provide sufficient information, as required by the Company, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

GRACE PERIOD

A grace period of thirty-one (31) days will be provided for the payment of any premium due after the first. During the grace period, the Policy shall continue in force, unless the Policyholder has given written notice of discontinuance in advance of the premium due date and in accordance with the Policy Term and Renewal provision.

Any renewal premium due must be paid, to Us, within the grace period following the renewal premium due date. If renewal premium is not paid within the thirty-one (31) day grace period, this Policy will automatically terminate at

the end of the grace period. The Policyholder will be liable for the payment of a pro rata premium for the time the Policy was in force during the grace period.

PREMIUM AUDIT

The Company will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

REINSTATEMENT

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are a written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, including the application (if any) and any attached amendments, endorsements, riders and/or attached papers represents the entire contract between the Policyholder and the Company. All statements made by the officers or trustees of the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No statement made by an Insured Person will be used in any contest under this Policy unless a copy of the statement is furnished to the Insured Person, or in the event of death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative. No change in this Policy will be effective until approved by one of Our officers. This approval must be in writing and endorsed on or attached to this Policy. No agent can change this Policy or waive any of its provisions.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which is in conflict with the requirements of any state or federal law that applies to this Policy is changed to conform to the minimum requirements of such laws. Premiums may be changed, in accordance with the Premium Rate Change provision, to reflect these requirements.

WORKERS' COMPENSATION

This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law. This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

ADDITION OF NEW INSURED PERSONS

All Insured Persons added to the Classes of Eligible Persons on the *Policy Schedule* are eligible for insurance under this Policy.

ASSIGNMENT

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if the Company receives it before any of those benefits have been paid and only for benefits payable for claims arising from the same Line of Duty Cancer claim. Any other attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

CLERICAL ERROR

An Insured Person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

EXAMINATION OF THE POLICY

This Policy will be available for inspection at the Policyholder's office during regular business hours.

INCONTESTABILITY

The validity of the Policy will not be contested for any claim incurred after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, material misrepresentation or fraud.

No misrepresentation will void or defeat recovery under this Policy unless such misrepresentation is material.

Absent a showing of intentional fraud, no statement made by any Insured Person relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless the statement is contained in a written instrument signed by the person making the statement.

However, the Company may contest coverage at any time based upon the Insured Person's ineligibility for coverage under the Policy or upon other provisions in the Policy.

MISSTATEMENT OF FACT

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

NONCOMPLIANCE WITH POLICY REQUIREMENTS

Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.

RECORDS

The Policyholder or its authorized Administrator will maintain the records of the Insured Person's insurance under this Policy. The Company will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Insured Person for transactions relating to this insurance. The actions of the Policyholder will not be considered the actions of the Company.

REPORTING REQUIREMENTS

The Policyholder or its authorized agent must report all of the following to the Company by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated; and
4. additional information required by the Company.

The Company may waive reporting of any information specified above.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

POLICY EFFECTIVE DATE

The Company agrees to provide the benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on the *Policy Schedule of Benefits*.

INSURED PERSON'S EFFECTIVE DATE

For a person in an Eligible Class shown on the *Policy Schedule of Benefits, c*overage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the date the person becomes a member of an Eligible Class; and
3. the date for which the first premium for the person's coverage is paid.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

INSURED PERSON'S TERMINATION DATE

An Insured Person's coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the Grace Period provision);
2. the date the Insured Person ceases to be a member of an Eligible Class;
3. the date the Policy terminates.

Termination does not affect a claim due to any Covered Line of Duty Cancer Diagnosis that occurs before the termination date.

EFFECTIVE DATE OF CHANGES

Any increase or decrease in the amount of insurance for the Insured Person resulting from a change in benefits provided by this Policy or a change in the Insured Person's covered class will take effect on the date of such change.

ELIGIBILITY

A person is eligible for insurance under this Policy on the date he or she meets all of the requirements of one of the Eligible Classes shown on the *Policy Schedule of Benefits.* An Eligible Person may be insured under only one covered class, even though he or she may be eligible under more than one covered class.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AXIS Insurance Company values its relationship with you. Protecting the privacy of the information we have about you is of great importance to us. We want you to understand how we protect the confidentially of information as well as how and why we use and disclose it. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to this information. "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare.

This privacy policy applies to policies underwritten by AXIS Insurance Company. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice. We reserve the right to change the terms of this notice, and should that occur, we will provide you with a copy of the new notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose your Protected Health Information (PHI) for the purposes of your treatment, for payment and for health care operations. Not every use or disclosure in a category is listed. However all of the ways that we may use or disclose PHI will fall within one of these categories.

Your Authorization: Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing use or disclosure. You may take away this authorization at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

For Payment: We use and disclose PHI as necessary for payment purposes. For example, we may use your PHI to process a claim or may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and disclose PHI for our health care operations such as customer service, premium rating, fraud and abuse prevention and detection, and other functions related to your health policy. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To Others: You may authorize us in writing to give your PHI to someone else for any reason. Also, if you are present, and provide authorization, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are unavailable, incapacitated, or facing an emergency medical situation, we may share limited PHI with a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also use or disclose your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared for any purpose as required by law.

We may share PHI with the sponsor of the plan or use in the administration of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

YOUR HIPAA PRIVACY RIGHTS

Access to Your PHI

You have the right to obtain a copy and inspect specific items of your PHI, such as your policy or claim information, for as long as we maintain it. We may deny your request to access certain PHI, as permitted or required by law. We may require your request for access in writing. Your request for access should contain as much detail as possible regarding the PHI you wish to review. We may charge a reasonable fee for access to your PHI.

Amendments to Your PHI

You have the right to request that the PHI we maintain about you be amended or corrected if you believe it is incorrect. We are not legally obligated to make all requested amendments but will give each request appropriate consideration. Requests for amendment must be in writing and must state the reasons for the amendment request.

Accounting for Disclosures of Your PHI

You have the right to request an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. Requests must be made in writing. We are not legally obligated to provide an accounting of every disclosure but will give each request appropriate consideration. The accounting will not include disclosures made prior to June 1, 2011.

Restrictions on Uses and Disclosures of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. We are not legally required to agree to your restriction request but will give each request appropriate consideration.

Confidential Communication of PHI

You have the right to request to receive communications from us regarding your PHI by another method of contact or at an alternative address. We will accommodate reasonable requests, which must clearly state that disclosure of all or part of the information could endanger your health or safety.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services in Washington, D.C. We will not take action against you for filing a complaint.

Contact Information

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the abovementioned rights, you may write to us at

Administrative Address:
AXIS Insurance Company
1 University Square Drive, Suite 200
Princeton, NJ 08540
888.870.AXIS (2947)
General questions - please send to USSales.AccHealth@axiscapital.com

Please include your name, address, plan sponsor, and policy number in any correspondence.

Effective June 1, 2011

OFAC NOTICE

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit AXIS Insurance Company from providing insurance, including, but not limited to, the payment of claims.

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulation, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

Underwritten by: AXIS Insurance Company
111 S. Wacker Drive
Suite 3500
Chicago, IL 60606
(A Stock Company)

Administrative Office: 1 University Square Drive, Suite 200, Princeton, NJ 08540

For inquiries, information about coverage or for assistance in resolving complaints:
Please dial the Florida Consumer Helpline at: 1-877-MY-FL-CFO (1-877-693-5236)
TDD line: 1-800-640-0886
Out of State: (850) 413-3089

Policyholder: **St. Johns County Board of County Commissioners**
Policy Number: **PRCA-97333-FL10044**
Effective Date of this Rider: October 1, 2022

To make an inquiry, obtain information about your coverage or to resolve a complaint call Toll Free: 888-870-AXIS (2947) / Direct Dial: 609-375-9190

AMENDATORY RIDER

This Rider is attached to and made part of the Policy as of the Effective Date shown above. It applies only with respect to a Line of Duty Cancer Diagnosis that occurs on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider. See the *Policy Schedule of Benefits* for the applicability of this Rider with respect to each class of Insured Persons.

I. The Line of Duty Cancer Diagnosis Lifetime Maximum in the **POLICY SCHEDULE OF BENEFITS** section of the Policy is deleted in its entirety and replaced with the following:

Lifetime Maximum Benefit	$50,000

The Lifetime Maximum Benefit does not apply to the Line of Duty Cancer Death Benefit.

II. The following Definition is added to the **DEFINITIONS** section of the Policy:

Lifetime Maximum Benefit means the maximum dollar amount this Policy and any attached riders will pay in benefits to an Insured Person during his or her lifetime. The Lifetime Maximum Benefit does not apply to the Line of Duty Cancer Death Benefit.

III. The following sentence, shown in the **Benefit Payment Conditions** sections of the **LINE OF DUTY CANCER INITIAL DIAGNOSIS BENEFIT,** in the BENEFITS section of the Policy, is deleted entirely:

"The Insured Person has not used tobacco products for at least five (5) years preceding Diagnosis;"

IV. The following class(es) of Eligible Persons are added to the **POLICY SCHEDULE** section of the Policy:

Eligible Persons:		
Class 3	An active full-time Civilian Fire Services Employee (as defined in this Policy)	Coverage Effective Date: the Policy Effective Date or the date on which the Eligible Person meets the Class 3 requirements whichever is later
Class 4	After having qualified as a Civilian Fire Services Employee in Class 3, a Civilian Fire Services Employee whose employment has terminated shall remain eligible for 10 years following the date on which Civilian Fire Services Employee terminates employment	Coverage Effective Date: the Policy Effective Date or the date on which the Eligible Person ceases to be a member of Class 3 and meets the Class 4 requirements whichever is later

V. The Line of Duty Cancer Death Benefit in the **POLICY SCHEDULE OF BENEFITS** section of the Policy is deleted in its entirety and replaced with the following:

Line of Duty Cancer Death Benefit – Class 1 and 3 Only
Benefit Amount $75,000

This benefit is an alternative to pursuing workers' compensation benefits under chapter 440

VI. With the exception of the **POLICY SCHEDULE** and the definition of Firefighter, all references to Firefighter in the **DEFINITIONS, BENEFITS,** and **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS** section of the Policy are amended as follows:

Firefighter or Civil Fire Service Employee

VII. All references to Firefighter in the **FIREFIGHTER CANCER EXPENSE REIMBURSEMENT BENEFIT RIDER** attached to the Policy are amended as follows:

Firefighter or Civil Fire Service Employee

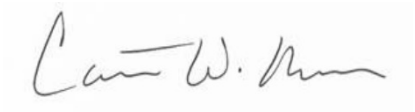
VIII. The following Definition is added to the **DEFINITIONS** section of the Policy.

Civilian Fire Service Employee means non-firefighting employee of a fire department or a public safety department of an Employer whose primary responsibilities are supporting those who provide prevention and extinguishing of fires; the protection of life and property; and the enforcement of municipal, county, and state fire prevention codes and laws pertaining to the prevention and control of fires.

TERMINATION OF THIS RIDER

This Rider will end on the earlier of:
1. the date we received written notice from the Policyholder to cancel this Rider; and
2. the date the Policy terminates.

The President and Secretary witness this Rider:



Secretary

President

Underwritten by: AXIS Insurance Company
111 S. Wacker Drive
Suite 3500
Chicago, IL 60606
(A Stock Company)

Administrative Office: 1 University Square Drive, Suite 200, Princeton, NJ 08540

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Policyholder: **St. Johns County Board of County Commissioners**
Policy Number: **PRCA-97333-FL10044**
Effective Date of this Rider: October 1, 2022

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FIREFIGHTER CANCER EXPENSE REIMBURSEMENT BENEFIT RIDER

This Rider is attached to and made part of the Policy as of the Effective Date shown above. It applies only with respect to a Line of Duty Cancer Diagnosis that occurs on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider. See the *Policy Schedule of Benefits* for the applicability of this Rider with respect to each class of Insured Persons. Any changes made to the Policy for purposes of this Rider shall only affect the benefits contained in the *Rider Schedule* and shall not have an effect on the *Policy Schedule of Benefits*.

This Rider is designed to extend coverage to Insured Persons who participate in the Employer-sponsored health plan or the Employer-sponsored group health insurance trust fund.

An Insured Person is eligible for benefits under this policy as an alternative to pursuing workers' compensation benefits under chapter 440. If the Insured Person is already paid workers' compensation benefits under chapter 440 they will not be eligible for benefits under this policy.

Coverage provided may not embody all benefits afforded to a Firefighter under Section 112.1816, F.S.

RIDER SCHEDULE

Line of Duty Cancer Expense Reimbursement Benefit
Benefit Amount up to $12,000 per Insured Person per Policy Term

BENEFIT

Line of Duty Cancer Expense Reimbursement Benefit
If, while coverage under this Policy is in force, an Insured Person is Diagnosed with Line of Duty Cancer and a Line of Duty Cancer Initial Diagnosis Benefit is payable under this Policy, the Company will pay the Benefit Amount shown in the Rider Schedule subject to the Lifetime Maximum Benefit, Diagnostic Requirements and Benefit Payment Conditions.

The Company will reimburse the following out-of-pocket expenses incurred by an Insured Person due to the treatment of Line of Duty Cancer:

- Deductible,
- Coinsurance, or
- Copayment.

The Company shall not pay more than the Benefit Amount shown in the Rider Schedule for all out-of-pocket expenses resulting from the same Line of Duty Cancer.

Diagnostic Requirements

The Company reserves the right to have any Line of Duty Cancer Diagnosis reviewed by a Physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to request an examination of either the Insured Person or the evidence used in arriving at such Diagnosis by an independently acknowledged expert selected by the Company in the applicable field of medicine.

The Line of Duty Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.

The opinion of such expert as to such Diagnosis shall be binding on both the Insured Person and the Company.

Benefit Payment Conditions

Payment of benefits is subject to:

1. the Diagnosis is made while the Insured Person's coverage is in force under the Policy;
2. the Insured Person has been employed as a Firefighter with the Employer for at least five (5) continuous years preceding Diagnosis;
3. The Insured Person has not been employed in any other position in the five (5) years preceding Diagnosis which is proven to create a higher risk for any cancer; and
4. The Line of Duty Cancer treatment is covered within the Employer-sponsored health plan or Employer-sponsored group health insurance trust fund.

No benefits will be payable for:

1. any disease, sickness or incapacity other than Line of Duty Cancer as defined; this is so even though such disease, sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Line of Duty Cancer;
2. any Line of Duty Cancer Diagnosis that occurs prior to the Policy Effective date;
3. any Line of Duty Cancer Diagnosis that occurs prior to the Insured Person's Coverage Effective Date;
4. any Line of Duty Cancer Diagnosis occurring after the Policy terminates;
5. any Line of Duty Cancer Diagnosis occurring after the Insured Person's coverage terminates.

Termination of Employment

If an Insured Person terminates employment with the Employer and a Line of Duty Cancer Initial Diagnosis Benefit is payable under this Policy, the Line of Duty Cancer Expense Reimbursement Benefit is payable upon Diagnosis of Line of Duty Cancer for 10 years following the date on which the Firefighter terminates his or her employment. The Company will pay the Benefit Amount shown in the Rider Schedule subject to the Diagnostic Requirements and Benefit Payment Conditions.

Benefit Payment Conditions

After termination of employment, payment of benefits is subject to:

1. the Diagnosis is made while the Insured Person's coverage is in force under the Policy;
2. after termination of employment, the Insured Person continued coverage in the Employer-sponsored health plan or Employer-sponsored group health insurance trust fund;

3. the Line of Duty Cancer treatment is covered within the Employer-sponsored health plan or Employer-sponsored group health insurance trust fund;
4. after termination of employment, the Insured Person was not subsequently employed as a Firefighter;
5. prior to termination of employment, the Insured Person was employed as a Firefighter with the Employer for at least five (5) continuous years;
6. the Insured Person has not been employed in any other position in the five (5) years preceding Diagnosis which is proven to create a higher risk for any cancer.

No benefits will be payable for:

1. any disease, sickness or incapacity other than Line of Duty Cancer as defined; this is so even though such disease, sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Line of Duty Cancer;
2. any Line of Duty Cancer Diagnosis that occurs prior to the Policy Effective date;
3. any Line of Duty Cancer Diagnosis that occurs prior to the Insured Person's Coverage Effective Date;
4. any Line of Duty Cancer Diagnosis occurring after the Policy terminates;
5. any Line of Duty Cancer Diagnosis occurring after the Insured Person's coverage terminates.

DEFINITIONS

Certain words used in this Rider have specific meanings. The words defined below and capitalized within the text of this Rider have the meanings set forth below. If a capitalized term is not set forth below, it may be defined in the Policy to which this Rider is attached. If a term contained in this Rider is defined in both the Policy and this Rider, the definition in this Rider shall govern.

Deductible means the amount the Insured Person must pay for covered health care services before his or her Employer-sponsored health plan or Employer-sponsored group health insurance trust fund will pay a claim.

Coinsurance means the percentage of costs of a covered health care service the Insured Person must pay (20%, for example) after he or she has paid the Deductible.

Copayment means the fixed amount ($20, for example) that the Insured Person must pay for a covered health care service after he or she has paid the Deductible.

RIDER EXCLUSIONS

In addition to any exclusions, conditions or limitations provided under the Policy, no Benefits shall be payable for the following treatments or services, unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Line of Duty Cancer;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.

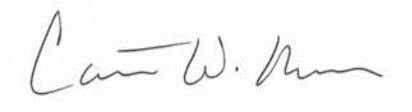
In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by Employer;
2. living in the Insured Person's household;
3. an Immediate Family Member of either the Insured Person or the Insured Person's Spouse;
4. the Insured Person.

TERMINATION OF THIS RIDER

This Rider will end on the earlier of:
1. the date we received written notice from the Policyholder to cancel this Rider; and
2. the date the Policy terminates.

The President and Secretary witness this Rider:



Secretary

President

Underwritten by: AXIS Insurance Company
111 S. Wacker Drive
Suite 3500
Chicago, IL 60606]
(A Stock Company)

Administrative Office: 1 University Square Drive, Suite 200, Princeton, NJ 08540

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AMENDATORY RIDER

I. The Line of Duty Cancer Death Benefit in the **POLICY SCHEDULE OF BENEFITS** section of the Policy is revised by the addition of the following:

Line of Duty Cancer Death Benefit – Class 2 and 4 Only
Benefit Amount $75,000

This benefit is an alternative to pursuing workers' compensation benefits under chapter 440.

II. The **LINE OF DUTY CANCER DEATH BENEFIT** provision under the BENEFITS section of the Policy is revised to include the following:

LINE OF DUTY CANCER DEATH BENEFIT – CLASS 2 and 4 ONLY
If, an Insured Person is diagnosed with a Line of Duty Cancer for which a Line of Duty Cancer Initial Diagnosis Benefit is payable, and he or she subsequently dies as a result of the Line of Duty Cancer or from circumstances that arise out of the treatment of the Line of Duty Cancer, the Company will pay the Benefit Amount shown in the Schedule of Benefits, subject to the following Benefit Payment Conditions.

Benefit Payment Conditions
Payment of Line of Duty Cancer Death Benefit is subject to the following:

1. the death must occur while the Insured Person's coverage is in force under the Policy; and
2. acceptable proof must be provided to the Company, or its authorized claims payor, that such death was a result of Line of Duty Cancer or circumstances that arise out of the treatment of the Line of Duty Cancer.

No benefits will be payable for:

1. any death that occurs due to any disease, sickness or incapacity other than Line of Duty Cancer as defined herein; even though such disease, sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Line of Duty Cancer;
2. any Line of Duty Cancer death that occurs prior to the Policy Effective Date;

3. any Line of Duty Cancer death that occurs prior to the Insured Person's Coverage Effective Date;
4. any Line of Duty Cancer death occurring after the Policy terminates; or
5. any Line of Duty Cancer death occurring after the Insured Person's coverage terminates.

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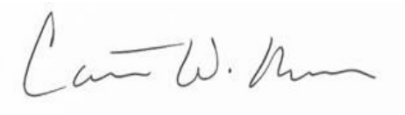
The President and Secretary witness this Rider:



Secretary

President