HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
1-800 447-0460

Specified Disease - Organ & Tissue Transplant Renewal Endorsement

Administrative Office:
HCC Life Insurance Company
4 Carter Green, Suite 400
Carmel, Indiana 46032
(833) 254-9537

This Endorsement is attached to and made a part of **Your** Certificate issued in relation to the following Specified Disease – Organ & Tissue Transplant Policy.

POLICYHOLDER:	City of Greensburg
ORIGINAL POLICY NUMBER:	HCCLOT40188
ORIGINAL EFFECTIVE DATE:	01/01/2019

It is agreed that the above referenced Specified Disease – Organ & Tissue Transplant Policy is renewed for the **Policy Year** stated in the attached Renewal Schedule of Benefits. The Policy Number and all terms and conditions set forth in the attached Renewal Schedule of Benefits replace and supersede all previously issued Schedules of Benefits.

This Endorsement is subject to all the provisions of the Policy. Payment of the premium for the insurance provided by the Policy as endorsed constitutes acceptance by the Policyholder of the terms of this Endorsement.

This Policy is issued by **Us** as of the **Policy Effective Date,** but is not valid unless countersigned by **Our** duly authorized representative.

President & CEO

Vice President and General Counsel

RENEWAL SCHEDULE OF BENEFITS

POLICY YEAR: 01/01/2026 through 12/31/2026

RENEWAL POLICY NUMBER: HCCLOT40188

CURRENT ENROLLMENT: 95

COVERED TRANSPLANTS: The following transplant procedures are covered as long as the transplant is the result of one of the **Covered Specified Diseases** set forth in the Appendix.

- ☒ Heart
- ☒ Lung/Double Lung
- ☒ Kidney (living or deceased donor)
- ☒ Pancreas
- ☒ Liver (living or deceased donor)
- ☒ Intestine
- ☒ Heart/ Lung
- ☒ Kidney/ Pancreas
- ☒ Kidney/Liver
- ☒ Liver/Intestine
- ☒ Pancreas/Intestine
- ☒ Liver/Pancreas/Intestine
- ☐ Other (specify):
- ☒ Autologous Bone Marrow Peripheral Stem Cell Including **High Dose Chemo**
- ☒ Allogeneic Bone Marrow - Peripheral Stem Cell – Cord Blood Including **High Dose Chemo** (related)
- ☒ Allogeneic Bone Marrow - Peripheral Stem Cell - Cord Blood Including **High Dose Chemo** (unrelated)

TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins on the date of Transplant Evaluation for a Covered Transplant Procedure.

The **Transplant Benefit Period** ends on the earliest of the following dates:

1. The end of the 365th day following the **Covered Transplant Procedure**;
2. The date the **Participant's** Lifetime Limit has been reached under the Policy, if applicable;
3. The date the Policy terminates, but only if:
   a. The **Policyholder** cancels the Policy prior to the last day of the current **Policy Year**; or
   b. The **Participant's** Transplant Benefit Period has begun, but such **Participant** has not received a **Covered Transplant Procedure** as of the date of termination of the Policy;
4. The date the **Participant's** COBRA benefits terminate, if applicable; or
5. The date established by the Non-Performance of Covered Transplant Procedures provision.

If there is no **Transplant Evaluation**, the **Transplant Benefit Period** begins on the date of a **Covered Transplant Procedure.**

For a bone marrow/peripheral stem cell tissue transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure.**

All benefits provided during a **Transplant Benefit Period** that extend beyond the **Policy Year** will be based on the Policy terms in effect at the start of the **Transplant Benefit Period.**

A **Transplant Benefit Period** cannot begin prior to the date the **Participant** first becomes covered under the Policy.

RENEWAL SCHEDULE OF BENEFITS
(Continued)

LIFETIME LIMIT: Unlimited

The following charges are included within and reduce each **Participant's** Lifetime Limit, if applicable:

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy or Specified Disease-Organ & Tissue Transplant Policy between the **Policyholder** and **Us**; and
2. All benefits paid by **Us** under the Travel Benefit provision.

REIMBURSEMENT AMOUNTS:

A. PARTICIPATING PROVIDER: ..... 100% of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Provider.**

B. NONPARTICIPATING PROVIDER: .....80% of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Provider** with respect to the type of **Covered Transplant Procedure** performed. Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Provider** will not exceed the Maximum Benefit stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT PROVIDER
Heart	$488,000
Lung (Single)	$349,000
Lung (Double)	$442,000
Kidney (living or deceased donor)	$170,000
Pancreas	$162,000
Liver (living or deceased donor)	$332,000
Intestine	$517,000
Heart/Lung	$745,000
Kidney/Pancreas	$253,000
Kidney/Liver	$637,000
Liver/Intestine	$738,000
Pancreas/Intestine	$738,000
Liver/Pancreas/Intestine	$738,000
Autologous Bone Marrow/Peripheral Stem Cell Including **High Dose Chemotherapy**	$200,000
Allogeneic Bone Marrow/Peripheral Stem Cell/Cord Blood Including **High Dose Chemotherapy** - related	$334,000
Allogeneic Bone Marrow/Peripheral Stem Cell/Cord Blood Including **High Dose Chemotherapy** - unrelated	$394,000

C. SECONDARY PAYER: ..... If any other medical plan pays benefits as primary, benefits under the Policy will be considered secondary. Such secondary benefits will be the lesser of: a) **Covered Charges** minus charges paid by the primary payer; or b) the negotiated amount established between the primary payer and the **Provider**, minus charges paid by the primary payer.

RENEWAL SCHEDULE OF BENEFITS
(Continued)

ENDORSEMENTS: Yes ☐ No ☒

If yes, please specify:

POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:

Dunn & Associates Benefit Administrators, Inc.

Questions regarding Your coverage or this Certificate should be directed to:

Tokio Marine HCC
4 Carter Green, Suite 400
Carmel, Indiana 46032
Attention: Robby Kerr
(833) 254-9537

If **You** need the assistance of the governmental agency that regulates insurance; or if **You** have a complaint with **Us** that has been unresolved, **You** may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461 or (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi