Schedule of Benefits

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Group Name: ARCAPITA INVESTMENT MANAGEMENT US INC
Group Number(s): 903719000 Effective Date: January 1, 2020

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Plan Pays" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period". Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application" column will indicate "no". If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application column. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Preferred Dentists accept the Maximum Allowable Charge as payment in full.

Service Category	*Waiting Period*	Plan Pays	Deductible Application
Diagnostic Services			
Oral Evaluations (Exams)	***None***	***100%***	***No***
Radiographs (X-Rays)			
Bitewings	***None***	***100%***	***No***
Full mouth	***None***	***100%***	***No***
Preventive Services			
Prophylaxis (Cleanings)	***None***	***100%***	***No***
Topical fluoride	***None***	***100%***	***No***
Sealants	***None***	***100%***	***No***
Space Maintainers	***None***	***80%***	***Yes***
Restorative Services			
Amalgam Restorations	***None***	***80%***	***Yes***
Resin Based Composite –Anterior (White Fillings)	***None***	***80%***	***Yes***
Resin Based Composite-Posterior (White Filling)	***None***	***80%***	***Yes***
Single Crowns	***None***	***50%***	***Yes***
Stainless Steel Crowns	***None***	***80%***	***Yes***
Inlays	***None***	***50%***	***Yes***
Onlays	***None***	***50%***	***Yes***
Inlay Repairs	***None***	***80%***	***Yes***
Onlay Repairs	***None***	***80%***	***Yes***
Crown Repair	***None***	***80%***	***Yes***
Endodontic Services			
Endodontic Therapy (Root canals, etc.)	***None***	***80%***	***Yes***
Root Canal Retreatment	***None***	***80%***	***Yes***

Service Category	*Waiting Period*	Plan Pays	Deductible Application
Apicoectomy/Periradicular (Root Surgery)	***None***	***80%***	***Yes***
Periodontal Services			
Surgical Periodontics	***None***	***80%***	***Yes***
Non-Surgical Periodontics	***None***	***80%***	***Yes***
Periodontal Maintenance	***None***	***80%***	***Yes***
Prosthodontic Services			
Removable Complete and Partial Dentures	***None***	***50%***	***Yes***
Adjustments and Repairs of Complete and Partial Dentures	***None***	***80%***	***Yes***
Removal of Teeth			
Simple Extractions	***None***	***80%***	***Yes***
Surgical Removal	***None***	***80%***	***Yes***
Adjunctive General Services			
Consultations	***None***	***100%***	***No***
General Anesthesia, Nitrous Oxide and/or IV Sedation	***None***	***80%***	***Yes***
Palliative Treatment (Emergency)	***None***	***100%***	***No***
Orthodontic Services			
Cosmetic Orthodontic Services	***None***	***0%***	***N/A***

Deductibles & Maximums

- *$50 per calendar year Deductible per Member not to exceed $150 per family*
- *$1,500 per calendar year Maximum per Member*

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

   For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.

   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

   For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.
11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.
21. For treatment and appliances for bruxism (night grinding of teeth).
22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.
23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:

    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.
25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.

27. Those specifically listed on the Schedule of Benefits as “Not Covered” or “Plan Pays 0%”.
28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
29. Orthodontic services, supplies, and appliances.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays - one (1) every 5 year(s).
2. Bitewing x-rays - one (1) set(s) per 12 months under age nineteen (19) and one (1) set(s) per 18 months age nineteen (19) and older.
3. Oral Evaluations:
    - Comprehensive and periodic - two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations - one (1) of these services per dentist per patient per 12 months.
    - Detailed problem focused - one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis - two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment - one (1) per 12 months under age fourteen (14).
6. Space maintainers - one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants - one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns - one (1) per tooth per lifetime for Members under age fourteen (14).
9. Periodontal Services:
    - Full mouth debridement - one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy - two (2) per 12 months in addition to routine prophylaxis.
    - Periodontal scaling and root planing - one (1) per 36 months per area of the mouth.
    - Surgical periodontal procedures - one (1) per 36 months per area of the mouth.
    - Guided tissue regeneration - one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations - not within 24 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch - not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.
12. Pulpal therapy - one (1) per eligible tooth per lifetime only when there is no permanent tooth to replace it.
13. Root canal retreatment - one (1) per tooth per lifetime.
14. Recementation - one (1) per 3 years. Recementation during the first 12 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.

15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Intraoral Films:
    - Periapical - four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal - two (2) per 24 months under age eight (8).
17. General anesthesia and IV sedation: a total of 60 minutes per session.

United Concordia Insurance Company

Dental Wellness Rider

This Rider is effective on the date issued to the Policyholder and is attached to and made a part of the Certificate of Insurance.

DEFINITIONS

The following defintion applies when used in this Rider.

Benefit Period – The time period specified that applies to each Limitation on the Schedule of Exclusions and Limitations. Benefit Periods shown on the Schedule of Exclusions and Limitations may be expressed in a number of months from the last Covered Service, a calendar year (12 months beginning in January and ending in December), a contract year (12 months beginning with the Effective Date of the Group Policy) or a Member's lifetime.

ELIGIBILITY

The additional Benefits in this rider are available to Members that meet at least one of the following criteria, unless other eligibility requirements are specified in the Schedule of Benefits Section of this Rider:

- Member is currently undergoing treatment for the following medical condition(s):
  - Coronary Artery Disease (CAD);
  - Cerebrovascular Disease (CVD);
  - Diabetes;
  - Lupus;
  - Pregnancy;
  - Rheumatoid Arthritis.

SCHEDULE OF BENEFITS

Plan Payment

In the grouping of dental services called *Exams* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for periodontal evaluations.

In the grouping of dental services called *Cleanings and Fluoride Treatments* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for prophylaxis (cleanings).

In the grouping of dental services called *Surgical Periodontics* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for the following Covered Service(s):

- Gingival flap procedures;
- Osseous surgeries.

In the grouping of dental services called *Non-Surgical Periodontics* on the Schedule of Benefits, the Plan will pay 100% of the Maximum Allowable Charge for the following Covered Service(s):

- Periodontal cleanings;
- Periodontal scaling and root planing.

Applicability of Plan Payments, Deductibles, Maximums and Waiting Periods

Except where otherwise specifically altered by this Rider, the Plan payments, annual Deductibles, Maximums and Waiting Periods shown on the Schedule of Benefits shall apply to the procedures covered under this Rider.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

Frequency Limitations

Member's that meet the requirements specified in the Eligibility section of this Rider are entitled to one treatment per Benefit Period in addition to the frequency listed in the Limitations section of the Schedule of Exclusions and Limitations for each of the following Covered Services:

- Periodontal cleanings following active periodontal therapy.

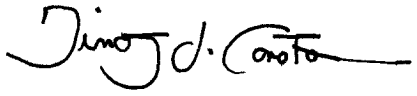
Applicability of Limitations and Exclusions

Except where otherwise specifically altered by this Rider, the Limitations and Exclusions listed in the Schedule of Exclusions and Limitations shall apply to the procedures covered under this Rider.

GENERAL

Except where specifically changed by this Rider, all of the terms and conditions of Your Plan's Certificate of Insurance, Schedule of Benefits and Schedule of Exclusions and Limitations also apply to this Rider. In the event of a conflict between the provisions in this Rider and the Certificate of Insurance, Schedule of Benefits or Schedule of Exclusions and Limitations, this Rider shall control.

UNITED CONCORDIA INSURANCE COMPANY



Officer's Signature