HEALTH BENEFITS WELCOME KIT

2023

tiger lines LLC

WHAT'S INSIDE

WELCOME

Dear Valued Team Member:

We understand how important benefits are to you, which is why we have selected high-quality benefit plans that encourage the well-being of you and your family. Your benefits give you access to the care you need, when you need it, and provide peace of mind that your family's finances will be protected in hard times.

We are excited to add a concierge service this year that will help you access and navigate through your benefits. This guide will provide a summary of your 2023 health benefit offerings. Please read this guide in its entirety to familiarize yourself with any changes and important steps you may need to take.

We are not making any changes this year other than adding the above-mentioned advocate concierge service, which is further discussed below. All providers are staying the same.

We are proud that you are part of the Tiger Lines team. Today's world is continually moving and we are here to move with you.

Sincerely,
Tiger Lines, LLC.
Human Resources

Member Advocate Concierge Service

New for 2023, we are adding a resource to help you understand your benefits and your financial responsibility after utilizing the medical plan.
Here's how it works…

- After **BRMS** receives & processes a claim they will send you an Explanation of Benefits (**EOB**), as well as an **HRA Statement** & a copy of an **HRA check** paid to the provider **if** HRA funds were available to use. The information explains what was covered & what your financial responsibility is for the services.

- **For claims with billed amounts over $250**, **BRMS** will follow up the above mailing with a phone call to you*, approximately 7-10 days after the above mailing, asking if you have any questions regarding your claim or the information sent.

  Be sure to complete the one-page BRMS 'HIPAA Consent Form/Release of Information' so that the BRMS Employee Advocate Concierge representative can call you. By law they cannot contact you unless this form is on file for each family member.

- If the advocate does not reach you live, they will leave you a voice message and include a toll-free phone number to call if you would like to discuss.

- We recommend adding **BRMS'** phone number to your contacts so if you do get a call from them, you will recognize it.

  The BRMS phone number to add to your contacts is (916) 467-1400.

CONTINUING IN 2023

Third-Party Administrator (TPA)

Tiger Lines has partnered with Benefit & Risk Management Services (BRMS) to provide you the best service in administering claims. Please see page 10 for additional details.

Medical ID Cards

You will not receive new ID cards for 2023. Please continue to use your current BRMS medical ID card.

Pre-certification Partner

In addition to administering your medical plan, BRMS will also handle your pre-certifications. Please see page 11 for additional details.

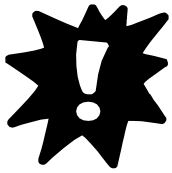
Medical Case Management

Medical Case Management will continue to be mandatory in 2023. Medical CaseManagement will provide you with tools, information, and the necessary people to help you stay healthy. If you have a condition that requires the medical case management team to become engaged, you will receive a call from the dedicated nurse team at BRMS. **Should you decide NOT to participate in the case management program, you will forfeit your coverage and will no longer be eligible for benefits under the Plan**. The coverage termination process will commence following a specified number of contact attempts by the case management department if no response is made within a timely fashion. This program allows us to ensure you are receiving the best care for your condition.

OUR DEDICATED HEALTH PARTNERS

PARTNER	ROLE	PHONE NUMBER	EMAIL/WEBSITE
Tiger Lines	Human Resources	1-209-367-3225	mnava@tigerlines.com
BRMS	Claims Administration Pre-Certification Case Management	1-844-317-9331	Tigerlines@brmsonline.com www.myhealthbenefits.com
ClaimDOC	Balance Bills	1-888-330-7295	membersupport@claim-doc.com balancebills@claim-doc.com
MagellanRx	Pharmacy Benefit Manager	1-800-424-0472	www.MagellanRx.com
Networks by Design	Physician and Ancillary Network	1-209-229-8695	www.NetByD.com
Unum	Dental	1-888-400-9304	www.unumdentalcare.com
VSP	Vision	1-800-877-7195	www.VSP.com
Unum	Life & AD&D	1-800-421-0344	www.unum.com

GET READY FOR OPEN ENROLLMENT!



OPEN ENROLLMENT:
November 28 - December 09

It's time to review your benefits! It is important to reevaluate your health benefits each year to ensure you are enrolled in the coverage that best fits your health care needs.

- **Update your personal information**: Make sure your address, email and other personal information is updated. If your information has changed, please contact Human Resources.
- **Review your dependents:** Take a look at your current dependent coverage to ensure accuracy and to verify they still meet the eligibility criteria. You must update your dependents (such as a new spouse or child) during Open Enrollment or within 31 days of a qualifying life event, or else you will not be able to add your dependent until the 2024 Open Enrollment period in 2023. See page 6 for details.
- **Gather all of your documents:** When you enroll, make sure you have the appropriate documentation. You will be required to provide each eligible dependent's Social Security number as well as information regarding your life insurance beneficiaries.
- **Plan to keep proof of enrollment:** Print or request a copy of your enrollment confirmation page as proof of enrollment.
- **DO YOU PLAN ON KEEPING THE SAME BENEFITS FOR 2023?**
  Tiger Lines is holding a **PASSIVE ENROLLMENT** this year, so nothing needs to be done if you are not making any changes.

If you plan on making changes to your benefits, or will be enrolling for the first time, you must log onto the BRMS enrollment platform to complete your enrollment.

RULES FOR BENEFIT CHANGES DURING THE YEAR

During your annual Open Enrollment you and your family are eligible to enroll, make changes or cancel your health benefits. Once the Open Enrollment period has ended, you may only make changes if you or a dependent experience a Qualifying Life Event (QLE). The Affordable Care Act (ACA) allows you to make the changes outlined in the chart below during a special enrollment period triggered by a QLE.

If you experience a Qualifying Life Event you will have 31 days from the date of the event to report the QLE, make changes to your benefits and provide any required supporting documentation.

	Initial Enrollment	Cancel Coverage	You May	Documentation
Loss of Other Coverage You and/or your dependent(s): • Lose other employer-sponsored coverage • Lose Medicaid/CHIP or Medicare • COBRA coverage is exhausted (non-payment of COBRA premium is not considered loss of coverage) • Are no longer eligible for student health coverage • Turned 26 years old and no longer qualify for a family plan	YES	NO	• Enroll in coverage • Enroll eligible dependent(s)	• Certificate of Credible Coverage • Formal letter from other employer, Medicaid or Medicare documenting date and reason for loss or discontinuation of coverage. o Or documenting effective date of new coverage
Gain of Other Coverage You and/or your dependent(s): • Gain other employer-sponsored coverage • Are now eligible for Medicaid, Medicare or CHIP	NO	YES	• Discontinue coverage for yourself or eligible dependent(s)	
Marriage	YES	YES	• Add spouse to coverage • Discontinue coverage ONLY if you are eligible for coverage through your spouse's employer, see "Gain of Other Coverage"	• Marriage Certificate/License • If canceling coverage and enrolling in spouse's, see "Gain of Other Coverage"
Divorce or Legal Separation	YES	YES	• Enroll in coverage if losing coverage under spouse's plan • Cancel spouse's or dependent's coverage	• Divorce Decree
Birth/Adoption/Legal Guardianship	YES	YES	• Enroll in coverage • Enroll eligible dependent(s) • Cancel if eligible for other coverage (see Gain of other coverage)	• Birth Certificate • Finalized Adoption Documents • Court Documents

Please note: Voluntarily terminating your other coverage or terminating due to non-payment does not constitute as Loss of Other Coverage. Also, you may NOT cancel your employer coverage to enroll in the public marketplace coverage after Open Enrollment has ended.

GOLD MEDICAL PLAN

The Tiger Lines Gold Plan combines the flexibility of a PPO plan with an employer-funded HealthReimbursement Account (HRA). You have the freedom to receive care from any in-network physicians and preventive care is covered at 100%. Copayments, coinsurance and deductibles accumulate towards the out-of-pocket maximum, and your HRA account is used to pay eligible healthcare expenses during the plan year.

Benefit Attributes	In-Network	Out-of-Network
Annual Deductibles Individual Family	$3,000 $6,000	
Out-of-Pocket Maximum Individual Family	$3,500 $7,000	$6,500 $13,000
Professional Services		
Preventive Care* See 12 for list of services	No Charge	No Charge
Office Visits Primary Care and Specialists	No Charge after Deductible	30% after Deductible
Lab and X Ray - Outpatient Routine Diagnostics Major Diagnostics (CT, PET, MRI, MRA and Nuclear) [1]	No Charge after Deductible	30% after Deductible
Hospital Services [1]		
Inpatient Services	No Charge after Deductible	30% after Deductible
Outpatient Services	No Charge after Deductible	30% after Deductible
Hospital Emergency Room	No Charge after Deductible	30% after Deductible
Home Health Care [2]	No Charge after Deductible	30% after Deductible
Skilled Nursing Facility [2]	No Charge after Deductible	30% after Deductible
Durable Medical Equipment [1]	No Charge after Deductible	30% after Deductible
Pharmacy	**In-Network**	
Retail (30-day supply) Generic Preferred Brand Non-Preferred Brand	$10 Co-pay after Deductible $30 Co-pay after Deductible $50 Co-pay after Deductible	
Mail Order (90-day supply) Generic Preferred Brand Non-Preferred Brand	$10 Co-pay after Deductible $60 Co-pay after Deductible $100 Co-pay after Deductible	

1 Pre-certification Required
2 Calendar Year Limits

Health Reimbursement Account

Annual Contribution

Team Member Only
$1,500

Team Member+ Dependent(s)
$3,000

Annual Roll-over Limit

Team Member Only
$1,500

Team Member+ Dependent(s)
$3,000

Note: Each year unused funds from one (1) calendar year will roll over to the next calendar year. Benefits are pro-rated for new participants effective after the beginning of the calendar year.

Gold Plan Rates

Tier	Weekly
Team Member Only	$42.00
Team Member + Spouse	$90.00
Team Member + Child(ren)	$80.00
Team Member + Family	$139.00

The weekly rates are pre-tax, which means they are taken out of your check before you are taxed. Because they are pre-tax, the actual amount that comes out of your check is significantly less than the amount of the deduction.

MAGELLAN RX PRESCRIPTION BENEFIT

Your prescriptions will continue to be administered through MagellanRx. No changes have been made to your coverage.

Did you know you can register on the MagellanRx portal to view your plan and pharmacy information?

By registering with MagellanRx's secure online Pharmacy Benefit Services, you are able to:

- View Benefit and Copay Information - Access information about your prescription drug benefits, including copay information for retail and mail orders
- Locate Network Pharmacies - Locating the nearest MagellanRx network pharmacy has never been easier. Member services gives you the option to input an address and locate the nearest participating network pharmacies to that address, including 24-hour pharmacies. Whether you need to pick up a prescription near home or work, you will always find themost convenient retail pharmacy to your location.
- View Medication History - Member services allows you to look at your medication history with MagellanRx including drug and quantity information, what your copay was and the date the prescription was filled.

To register with MagellanRx, follow these steps:

1. Go to www.MagellanRx.com.
2. Click on the "Member Portal" button located in the center of the website.Click
3. on the link labeled "Click here to register with Magellan".
4. Complete the secure online registration form. You must have your ID to register. Your member ID can be found on your medical ID card.

NETWORKS BY DESIGN

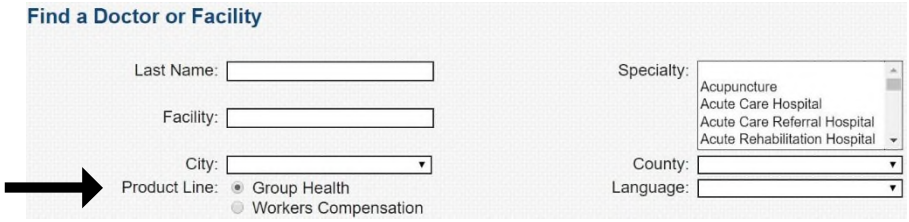
Tiger Lines will continue to partner with Networks by Design (NBD) to offer you a larger selection of in-network medical providers in your area. *(Facilities, such as hospitals and outpatient surgery centers, are "open access", meaning you may visit any facility and receive in-network benefits.)*

To find professional providers or ancillary benefit providers (i.e. Labs and X-Rays) within your network, please follow these steps:

1. Visit NBD's website at: www.NetByD.com

2. Click on the "Find a Doctor or Facility" tab located at the top of the page below NBD's logo

3. Click on "Group Health" under the "Provider Line" section.



4. Enter the minimum search criteria
   - Name of the Provider and/or Specialty
   - Location

5. Click Search

If your provider is not within the NBD network, you may click on "Nominate a Provider", complete the form and click "Submit". Networks by Design will receive your nomination and notify you via e-mail of the Recruitment Specialist who will personally be contacting the provider. You are invited to contact the Recruitment Specialist to obtain status of a nominated provider.

As always, you may call your Tiger Lines Benefit Help Line for assistance in finding a provider.

MyHealthBenefits™
A BRMS Solution

With MyHealthBenefits from BRMS, you are able to do much more than enroll in benefits. The platform allows you to add or remove dependents, modify beneficiary designations and access a comprehensive resource library with important information about your plan.

After the Open Enrollment period, the system is available year-round to check your benefit information or record a family status change. This reference guide will help you log into your benefits system and walk you through the enrollment process. Let's get started.

LOGGING IN

1. In your web browser, enter:
   www.myhealthbenefits.com
2. You will be directed to the benefits system login page. All new users will be required to go through the registration process to create a new username and password.
3. To register for an account, click Create New Account. If you have already registered for a new account, skip steps 4-5.
4. Complete the registration process. You will be required to validate your account with an active email address.
5. Once your email address has been validated, your account has been successfully created. Click Log In to enter your account.
6. Enter your username and password, and the system will prompt you to validate your identity by entering a code (sent via phone call, text message or email). This second step in the authentication process will be required every time an attempt to access your account is made from a device the system does not recognize.
7. Upon completing the multi-factor verification, you will be taken to your benefits dashboard.

ENROLLING IN BENEFITS

1. On your benefit's dashboard, click Open Enrollment.
2. Before you begin your enrollment, you will be asked to verify your personal information. To begin the verification process, click Get Started.
3. When you have finished the verification process, click Proceed to Open Enrollment to begin enrolling in benefits.
4. Starting with your first Benefit Election, MyHealthBenefits will guide you through the election process for all benefit types available to you.
5. Click the appropriate option/link that indicates the action you want to take for each benefit type available to you. If you want to change any of your elections, click I would like to change my election. When making changes, use the Next and Back buttons to move from page to page. If you make changes, be sure to click Save after making each change.
6. If you are satisfied with your elections, click the red button labeled Click here to submit your elections to complete your enrollment.
7. You will then be prompted to print or save a summary.

brms

MEDICAL PRE-CERTIFICATION

Your medical plan requires that certain procedures be pre-certified before they are performed. Pre-certification helps determine if the course of treatment you will receive is both medically necessary and cost effective. Pre-certification services are provided by BRMS.

Most often the ordering physicians will coordinate the pre-certification, however, it is up to you as the member to ensure that your physician has completed the proper steps to pre-certify the procedure. Should you undergo the procedure without prior approval on file, the allowed charges on the claim will be reduced by $500 and you will be responsible for payment of the part of the charge that is not paid by the plan. Since this is considered a penalty, it will not apply to the deductible or out-of-pocket maximum.

Please familiarize yourself with the list of services that are required to be pre-certified.

- Inpatient Hospitalization
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue)
- All outpatient procedures not performed in a physician's office, including freestandingAmbulatory Surgical Centers (ASC)
- Chemotherapy
- Radiation Therapy
- Durable Medical Equipment greater than $500 MRI,
- MRA, CT, CTA, PET, PECT CT, Arthrogram
- Nuclear Imaging Cardiac
- Rehabilitation
- Therapy: Physical, occupational and speech therapyIV
- Therapy
- Home Healthcare
- Hospice
- Intensive Outpatient Program for Mental Health Partial
- Hospitalization Program for Mental Health

MEDICAL PREVENTIVE CARE SERVICES

The following is a summary of the preventive health services that the Tiger Lines medical plan cover at 100%, should they be performed by an in-network physician. Please pay attention to the details of each service, as there may be age requirements. For additional details, please visit www.healthcare.gov.

15 Covered Services for Adults

1. Abdominal aortic aneurysm one-time screening for men 65-75 who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men ages 45-79 and women ages 55-79 to prevent CVD when prescribed by a physician
4. Blood Pressure screening
5. Cholesterol screening for adults
6. Colorectal Cancer screening for adults starting at age 50 (limited to one every 5 years)
7. Depression screening
8. Type 2 Diabetes screening
9. Diet counseling
10. HIV screening
11. Immunization vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps Rubella Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella)
12. Obesity screening and counseling
13. Sexually Transmitted Infection prevention counseling
14. Tobacco Use screening and cessation intervention
15. Syphilis screening

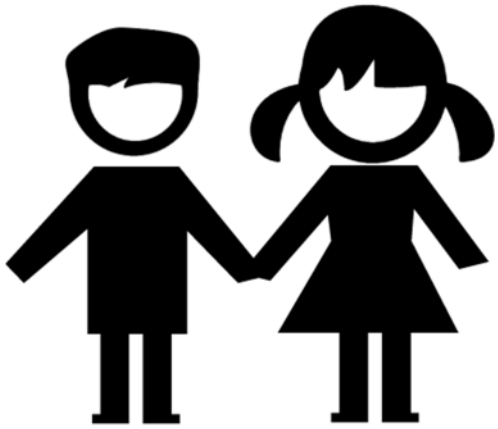
22 Covered services for Women

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling and genetic testing for women at high risk
4. Breast Cancer Mammography screenings every year for women aged 40 and over
5. Breast Cancer Chemo Prevention counseling for women
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk.
9. Contraception: FDA approved
10. Domestic and interpersonal violence screening
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk for developing gestational diabetes
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV Screening and counselling for sexually active women.
16. High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening for women over 60
18. Rh Incompatibility screening for all pregnant women
19. Tobacco Use screening and interventions
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women
22. Well-women visits to obtain recommended preventive services.

MEDICAL PREVENTIVE CARE SERVICES CONTINUED

26 Covered Services for Children

1. Alcohol and Drug Use assessments
2. Autism screening for children limited to two screenings up to 24 months
3. Behavioral assessments for children, limited to 5 assessments up to age 17
4. Blood Pressure screening
5. Cervical Dysplasia screening
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents aged 12 and older
8. Developmental screening for children under age 4
9. Dyslipidemia screening for children
10. Fluoride Chemo Prevention supplements for children without fluoride in their water source when prescribed by a physician
11. Gonorrhea preventive medications for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for all children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children to age 18. Doses, recommended ages, and populations may vary.
18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk for exposure
20. Medical History for all children throughout development
21. Obesity screening and counseling
22. Oral Health risk assessment for young children
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higherrisk
26. Vision screening for all children



MEDICAL BALANCE BILLS

Your health plan utilizes a claim review and audit program that determines the fair and reasonablecost for the medical services you receive. A balance bill occurs when a provider or hospital receives the fair and reasonable payment from your insurance but seeks to collect the additional amounts directly from you.

The balance sought to be collected against you will likely match the discount determined by your plan as reflected on the Explanation of Benefits (EOB) you receive from BRMS, your third-party benefits administrator.

Example

You fall, break an ankle and visit the emergency room. The total cost comes out to be $1,000 for this visit and a claim is submitted to BRMS.

Bill Charges: $1,000
Discount: $600
Patient Responsibility: $400

You've paid your employee responsibilityof $400, but later receive a bill for the discounted amount of $600.

This is a balance bill.

ClaimDOC®
Fair Payment Solutions for Health Plans

What to Do if You Receive a Balance Bill

1. Make sure your copay, deductible and/or patient responsibility is paid.

2. Immediately inform ClaimDOC that you have received a balance bill.

3. You will be asked to sign proper documentation granting ClaimDOC authorization to handle the bill on your behalf. This service is provided to you by your health plan.

4. ClaimDOC will then contact the provider (or collection agency) regarding the balance bill and keep you updated on the process.

5. If you continue to receive balance bills OR receive any other communications, let ClaimDOC know immediately!

1-888-330-7295

balancebills@claim-doc.com

ClaimDOC®
Fair Payment Solutions for Health Plans

UNDERSTAND YOUR BENEFITS AND GET THE HELP YOU NEED

ClaimDOC's member advocates are prepared to assist you with your benefits questions.

Assistance with finding a doctor or other provider of medical services

If you need assistance in finding a primary care physician, specialist, labs, radiology, facilities, or you simply need a less costly provider.

ClaimDOC is there for you

Scheduling Appointments

When you need a regular appointment or need to coordinate appointments with your physician and specialist,

ClaimDOC is there for you

Understanding your bills and Explanation of Benefits (EOB)

If you need assistance reviewing your bill, determining patient responsibility, correcting errors etc...

ClaimDOC is there for you

1-888-330-7295

membersupport@claim-doc.com

TIGER LINES LLC

Unum Dental™

Dental Insurance can help you payfor dental exams, cleanings, and other services.

How does it work?

Good dental care is critical to your overall well-being. WithUnum Dental insurance, you can get the attention your teeth need — at a cost you can afford.

Unum Dental allows you to see any dentist you choose.To get the most from your benefits and reduce out-of-pocket costs, choose an in-network provider by utilizing our large national network. These providers have agreed to fileyour claims and uphold the highest quality standards. You can find in-network providers at unumdentalcare.com.

Why is this coverage so valuable?

- Routine dental care keeps your mouth and whole body healthy.
- Your plan is backed by Unum's commitment to excellence in customer service.
- Personalized website and mobile app to manage your benefits including claims information, ID cards and more.
- There's no waiting period for preventive and basic services.

Dental High Plan

What else is included?

Pregnancy benefit

An extra cleaning for expecting mothers in their 2nd or 3rd trimester.

Wellness benefits

Oral cancer screenings for patients 40 and older withhigh risk factors.

Unumdentalcare.com

Use unumdentalcare.com and the mobile app search for providers, manage your benefits and learn about good dentalhealth. Features include easy access to ID Cards, claims history and coverage information.

Carryover benefits

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! Carryover benefits will be accrued and stored in the insured's carryoveraccount to be used in the next benefit year.

The limits for this policy/certificate are:	Passive PPO
Carryover benefit	$400
Threshold limit	$800
Carryover account limit	$1,500

Coverage details and costs

Overview	Passive PPO
Benefit Year Maximum*	$2,500
Deductible**	$50 per benefit year Maximum 3 per family

Plan Coinsurance	In-network	Non-network
Class A Preventive	100%	100%
Class B Basic	80%	80%
Class C Major	50%	50%
Class D Orthodontics	50%	50%

*Applies to Class A, B and C Services, if applicable
**Waived for Class A (applies to Class B and C Services)

Dental carryover benefit and how it works

Each benefit year a member must have:

- One cleaning,
- One regular exam, and
- Total dental claims for preventive, basic and major covered procedures paid during the year below the threshold limit.
- If all three criteria above are met, a portion of the annual maximum will carry over to the next year.

Other Specifications:

- Each covered family member receives their own carryoverbenefit.
- Group carryover benefit rider must be in effect for onebenefit year before any members can utilize carryoverbenefits.
- A member must be on the plan for a minimum of threemonths before accruing carryover benefits.
- Carryover benefit may be used toward preventive, basic and major covered services only
- A member's carryover account will be eliminated, and the accrued carryover benefits lost if the insured has a break incoverage for any length of time or any reason.

Dependent children

Dependent age guidelines vary by state. Please refer toyour policy certificate or contact customer service at (888) 400-9304.

Services not listed

If you expect to require a dental service not included on this brochure, it may still be covered. Please contact customer service at (888) 400-9304 to confirm your exact benefits.

Alternate treatment

Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment but will beresponsible for the cost difference resulting from the more expensive procedure.

Covered Procedures& Waiting Periods	Passive PPO
CLASS A **PREVENTIVE SERVICES**	Waiting Period: None • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) – (1 additional cleaning or periodontal maintenance per 12 months, ifmember is in 2nd or 3rd trimester of pregnancy) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36months) • Emergency Treatment (1 per 12 months) • Full mouth/panoramic x-rays (1 per 36 months)
CLASS B **BASIC SERVICES**	Waiting Period: None • Space Maintainers for children up to age 16 (1 per 24 months) • Simple restorative services (fillings; Benefit allowed for amalgam restorations on posterior teeth) • Simple extractions • Oral Surgery (extractions and impacted teeth) • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture, or bridge • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Periodontal maintenance in combination with prophylaxis) • Endodontics (root canals)
CLASS C **MAJOR SERVICES**	Waiting Period: None • Inlays and Onlays • Crowns, Bridges, Dentures, and Implants
CLASS D **ORTHODONTICS**	Waiting Period: None • Separate Lifetime Maximum: $1,500 • Up to 25% of lifetime allowance may be payable on initial banding • All Insureds

Refer to your certificate of coverage for the services covered under your plan.

Exclusions and Limitations

Unum members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Otherimplants or implant related services are not covered. The following dental services are not covered unless stated otherwise in the Certificate of Coverage:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American DentalAssociation, as well as any replacement of prior elective or cosmetic restorations.
- the correction of congenital malformations.
- replacement of a removable device or appliance that is lost, missing, or stolen, and for the replacement of removable appliances that have been damageddue to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or dentures.
- replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation inthe Schedule of Covered Procedures. This may include but not be limited to bridges, dentures, and crowns.
- any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion.
- any appliance, service or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis.
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, or dentures and anyassociated surgery, or other customized services or attachments.
- services provided for any type of temporomandibular joint (TMJ) dysfunction, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.

Limitations:

- Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. On anygiven day, more than 8 periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph. Pre-estimates arerecommended for any treatment expected to exceed $300.

Takeover benefits:

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under theemployer's previous plan during the month prior to coverage moving to us. Application of takeover benefits is subject to Underwriting review and approval.

New hires with prior-like dental coverage (lapse in coverage must be less than 63 days) will receive takeover credit for the length of time they had withthe prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e. one page benefit summary, Certificate ofCreditable Coverage, etc.).

Late entrants:

Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coveragewith Unum will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying. The prior carrier is responsible for reimbursement of costs for procedures begun prior to the effective date.

Better benefits at work.™

unum.com

A Network Access plan is available.

THIS POLICY PROVIDES LIMITED BENEFITS

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, pleaserefer to Policy Form Series Dental DN-2002, DN-2007 and DN-2015 or contact your Unum Dental representative.

Underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

 EN-2026 FOR EMPLOYEES (06-21)

Dental High Plan Employee Contributions

	Weekly
Team Member:	$9.50
Team Member + Spouse:	$19.00
Team Member + Child(ren):	$22.00
Team Member + Family	$33.00

TIGER LINES LLC

Unum Dental™

Dental Insurance can help you payfor dental exams, cleanings and other services.

How does it work?

Good dental care is critical to your overall well-being. WithUnum Dental insurance, you can get the attention your teeth need — at a cost you can afford.

Unum Dental allows you to see any dentist you choose.To get the most from your benefits and reduce out-of-pocket costs, choose an in-network provider by utilizing our large national network. These providers have agreed to fileyour claims and uphold the highest quality standards. You can find in-network providers at unumdentalcare.com.

Why is this coverage so valuable?

- Routine dental care keeps your mouth and whole body healthy.
- Your plan is backed by Unum's commitment to excellence in customer service.
- Personalized website and mobile app to manage your benefits including claims information, ID cards and more.
- There's no waiting period for preventive and basic services.

Dental Low Plan

What else is included?

Pregnancy benefit

An extra cleaning for expecting mothers in their 2nd or 3rd trimester.

Wellness benefits

Oral cancer screenings for patients 40 and older withhigh risk factors.

Unumdentalcare.com

Use unumdentalcare.com and the mobile app search for providers, manage your benefits and learn about good dentalhealth. Features include easy access to ID Cards, claims history and coverage information.

Carryover benefits

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! Carryover benefits will be accrued and stored in the insured's carryoveraccount to be used in the next benefit year.

The limits for this policy/certificate are:	Passive PPO
Carryover benefit	$350
Threshold limit	$700
Carryover account limit	$1,250

Coverage details and costs

Overview	Passive PPO
Benefit Year Maximum*	$1,500
Deductible**	$50 per benefit year Maximum 3 per family

Plan Coinsurance	In-network	Non-network
Class A Preventive	100%	100%
Class B Basic	80%	80%
Class C Major	50%	50%

*Applies to Class A, B and C Services, if applicable
**Waived for Class A (applies to Class B and C Services)

Dental carryover benefit and how it works

Each benefit year a member must have:

- One cleaning,
- One regular exam, and
- Total dental claims for preventive, basic and major covered procedures paid during the year below the threshold limit.
- If all three criteria above are met, a portion of the annual maximum will carry over to the next year.

Other Specifications:

- Each covered family member receives their own carryoverbenefit.
- Group carryover benefit rider must be in effect for onebenefit year before any members can utilize carryoverbenefits.
- A member must be on the plan for a minimum of threemonths before accruing carryover benefits.
- Carryover benefit may be used toward preventive, basic and major covered services only
- A member's carryover account will be eliminated, and the accrued carryover benefits lost if the insured has a break incoverage for any length of time or any reason.

Dependent children

Dependent age guidelines vary by state. Please refer toyour policy certificate or contact customer service at (888) 400-9304.

Services not listed

If you expect to require a dental service not included on this brochure, it may still be covered. Please contact customer service at (888) 400-9304 to confirm your exact benefits.

Alternate treatment

Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment but will beresponsible for the cost difference resulting from the more expensive procedure.

Covered Procedures& Waiting Periods	Passive PPO
CLASS A PREVENTIVE SERVICES	Waiting Period: None • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) – (1 additional cleaning or periodontal maintenance per 12 months, ifmember is in 2nd or 3rd trimester of pregnancy) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36months) • Emergency Treatment (1 per 12 months) • Full mouth/panoramic x-rays (1 per 36 months)
CLASS B BASIC SERVICES	Waiting Period: None • Space Maintainers for children up to age 16 (1 per 24 months) • Simple restorative services (fillings; Benefit allowed for amalgam restorations on posterior teeth) • Simple extractions • Oral Surgery (extractions and impacted teeth) • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture, or bridge • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Periodontal maintenance in combination with prophylaxis) • Endodontics (root canals)
CLASS C MAJOR SERVICES	Waiting Period: None • Inlays and Onlays • Crown, Bridges, Dentures, and Implants

Refer to your certificate of coverage for the services covered under your plan.

Exclusions and Limitations

Unum members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Otherimplants or implant related services are not covered. The following dental services are not covered unless stated otherwise in the Certificate of Coverage:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American DentalAssociation, as well as any replacement of prior elective or cosmetic restorations.
- the correction of congenital malformations.
- replacement of a removable device or appliance that is lost, missing, or stolen, and for the replacement of removable appliances that have been damageddue to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or dentures.
- replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation inthe Schedule of Covered Procedures. This may include but not be limited to bridges, dentures, and crowns.
- any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion.
- any appliance, service or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis.
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, or dentures and anyassociated surgery, or other customized services or attachments.
- services provided for any type of temporomandibular joint (TMJ) dysfunction, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.

Limitations:

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 EN-2026 FOR EMPLOYEES (06-21)

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unum.com

Dental Low Plan Employee Contributions

	Weekly
Team Member:	$9.00
Team Member + Spouse:	$18.00
Team Member + Child(ren):	$18.00
Team Member + Family	$28.00

VISION PLAN

Tiger Lines offers you vision coverage through Vision Service Plan (VSP). VSP provides coverage for eye exams and materials, such as lenses and frames. By visiting a participating VSP provider, you will get the most out of your benefit and have lower out-of-pocket costs.
Please visit www.VSP.com to find a provider in your area.

Vision Plan
Employee Contributions

	Weekly
Team Member Only	$1.00
Team Member + Spouse	$2.00
Team Member + Child(ren)	$2.00
Team Member + Family	$3.00

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$20
Prescription Glasses		$20
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance • Every other calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every other calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every other calendar year	$55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every other calendar year	Up to $60
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	
	Your Coverage with Out-of-Network Providers	
	Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider. Exam ..... up to $45 Frame ..... up to $70 Single Vision Lenses ..... up to $30 Lined Bifocal Lenses ..... up to $50 Lined Trifocal Lenses ..... up to $65 Progressive Lenses ..... up to $50 Contacts ..... up to $105	
	Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.	

BASIC LIFE AND AD&D

If you have loved ones who depend on your income for support, having Life and Accidental Death & Dismemberment insurance can help protect your family's financial security. Tiger Lines provides you with a Basic Life and AD&D insurance policy at no cost to you.

Basic Life provides income protection for your beneficiary(ies) in the event of your passing. AD&D provides another layer of benefits for you, or your beneficiary(ies) should you suffer from loss of a limb, speech, sight, hearing or if your passing is due to an accident.

	Basic Life Amount	**AD&D Amount**
Class 1: **Full-Time Employees**	$30,000	$30,000

GLOSSARY

Deductible: The amount that you pay each year before the plan begins to pay its coinsurance percentage. Expenses that count towards your deductible also counttowards your out-of-pocket maximum.

Out-of-Pocket Maximum: The maximum amount you could pay each year for the deductible and coinsurance. After you reach your out-of-pocket maximum, the plan pays100 percent of eligible expenses for the rest of the year.

Coinsurance: The percentage of covered expenses that you and the plan pay after thedeductible is met. For example, of the plan pays 70 percent, your coinsurance will be 30percent.

Health Reimbursement Account: Employer funded account that helps you pay foreligible medical expenses such as your deductible.

Generic Drug: Contain the same active ingredients as more costly alternatives but are not sold using a brand name.

Preferred Brand: Brand name drugs that are available to you at lower cost.

Non-Preferred Brand: Brand name drugs that may be purchased at a higher cost