

## 2026 Hourly Benefit Summary

Our employees are our most valuable asset. That is why at Five Star Call Centers, we are committed to a comprehensive benefit program that helps our employees stay healthy, feel secure and maintain a positive work-life balance.

Below is a snapshot that provides you with information for each benefit we offer effective 8/01/2026 to 7/31/2027.

| Type of Benefit                                                                                              |                         | Deduction                           | Plan Information                      |                                                                                   |
|--------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------|
| <b>MEDICAL INSURANCE</b>                                                                                     |                         | <b>Wellmark</b>                     |                                       |                                                                                   |
| <b>\$4,000 PPO Plan</b>                                                                                      |                         |                                     |                                       |                                                                                   |
| Deductible:                                                                                                  | January 1 - December 31 | <b>Employee Deduction</b>           | <b>Deductible: Single / Family</b>    | \$4,000 / \$8,000                                                                 |
| Plan Year:                                                                                                   | 8/1/2026                | <b>Rate Per Paycheck (48)</b>       | <b>Coinsurance</b>                    | 50% Wellmark                                                                      |
| Website:                                                                                                     | wellmark.com            | <u><b>Employee Only</b></u>         |                                       | 50% Member                                                                        |
| Contact:                                                                                                     | 800-524-9242            | \$71.10 Non-Tobacco                 | <b>Out of Pocket: Single / Family</b> | \$8,000 / \$16,000                                                                |
|                                                                                                              |                         | \$101.10 Tobacco                    | <b>Office Visit</b>                   | Primary Care \$25 Copay                                                           |
|                                                                                                              |                         | <u><b>Employee + Spouse</b></u>     |                                       | Specialty Care \$75 Copay                                                         |
|                                                                                                              |                         | \$212.91 Non-Tobacco                |                                       | Telehealth \$0                                                                    |
| <b>Spousal Surcharge of \$100 Monthly apply if spouse has access to other coverage.</b>                      |                         | \$251.66 Tobacco                    | <b>Prescription Drug:</b>             |                                                                                   |
|                                                                                                              |                         | <u><b>Employee + Child(ren)</b></u> | <b>Tier 1 - Generics</b>              | \$0 Copay                                                                         |
|                                                                                                              |                         | \$184.70 Non-Tobacco                | <b>Tier 2</b>                         | 25% up to \$200                                                                   |
|                                                                                                              |                         | \$223.45 Tobacco                    | <b>Tier 3</b>                         | 50% up to \$200                                                                   |
|                                                                                                              |                         | <u><b>Employee + Family</b></u>     | <b>Tier 4</b>                         | Deductible & Coinsurance                                                          |
|                                                                                                              |                         | \$398.71 Non-Tobacco                |                                       |                                                                                   |
|                                                                                                              |                         | \$437.46 Tobacco                    |                                       | Preventive Care, Screening, and Immunization Covered at No Charge                 |
| <b>\$4,750 PPO Plan</b>                                                                                      |                         |                                     |                                       |                                                                                   |
| Deductible:                                                                                                  | January 1 - December 31 | <b>Employee Deduction</b>           | <b>Deductible: Single / Family</b>    | \$4,750 / \$9,500                                                                 |
| Plan Year:                                                                                                   | 8/1/2026                | <b>Rate Per Paycheck (48)</b>       | <b>Coinsurance</b>                    | 50% Wellmark                                                                      |
| Website:                                                                                                     | wellmark.com            | <u><b>Employee Only</b></u>         |                                       | 50% Member                                                                        |
| Contact:                                                                                                     | 800-524-9242            | \$68.77 Non-Tobacco                 | <b>Out of Pocket: Single / Family</b> | \$9,100 / \$16,200                                                                |
|                                                                                                              |                         | \$98.77 Tobacco                     | <b>Office Visit</b>                   | Primary Care \$35 Copay                                                           |
|                                                                                                              |                         | <u><b>Employee + Spouse</b></u>     |                                       | Specialty Care \$80 Copay                                                         |
|                                                                                                              |                         | \$205.93 Non-Tobacco                |                                       | Telehealth \$0                                                                    |
| <b>Spousal Surcharge of \$100 Monthly apply if spouse has access to other coverage.</b>                      |                         | \$244.68 Tobacco                    | <b>Prescription Drug:</b>             |                                                                                   |
|                                                                                                              |                         | <u><b>Employee + Child(ren)</b></u> | <b>Tier 1 - Generics</b>              | \$0 Copay                                                                         |
|                                                                                                              |                         | \$178.64 Non-Tobacco                | <b>Tier 2</b>                         | 25% up to \$150                                                                   |
|                                                                                                              |                         | \$217.39 Tobacco                    | <b>Tier 3</b>                         | 50% up to \$150                                                                   |
|                                                                                                              |                         | <u><b>Family</b></u>                | <b>Tier 4</b>                         | Deductible & Coinsurance                                                          |
|                                                                                                              |                         | \$385.64 Non-Tobacco                |                                       |                                                                                   |
|                                                                                                              |                         | \$424.39 Tobacco                    |                                       | Preventive Care, Screening, and Immunization Covered at No Charge                 |
| <b>\$6,000 HDHP</b>                                                                                          |                         |                                     |                                       |                                                                                   |
| Deductible:                                                                                                  | January 1 - December 31 | <b>Employee Deduction</b>           | <b>Deductible: Single / Family</b>    | \$6,000 / \$12,000                                                                |
| Plan Year:                                                                                                   | 8/1/2026                | <b>Rate Per Paycheck (48)</b>       | <b>Coinsurance</b>                    | 80% Wellmark                                                                      |
| Website:                                                                                                     | wellmark.com            | <u><b>Employee Only</b></u>         |                                       | 20% Member                                                                        |
| Contact:                                                                                                     | 800-524-9242            | \$37.49 Non-Tobacco                 | <b>Out of Pocket: Single / Family</b> | \$7,500 / \$15,000                                                                |
|                                                                                                              |                         | \$53.74 Tobacco                     | <b>Office Visit</b>                   | Primary Care Deductible & Coinsurance                                             |
|                                                                                                              |                         | <u><b>Employee + Spouse</b></u>     |                                       | Specialty Care Deductible & Coinsurance                                           |
|                                                                                                              |                         | \$158.67 Non-Tobacco                |                                       | Telehealth Deductible & Coinsurance                                               |
| <b>Spousal Surcharge of \$100 Monthly apply if spouse has access to other coverage.</b>                      |                         | \$197.42 Tobacco                    | <b>Prescription Drug:</b>             |                                                                                   |
|                                                                                                              |                         | <u><b>Employee + Child(ren)</b></u> | <b>Tier 1 - Generics</b>              | Deductible & Coinsurance                                                          |
|                                                                                                              |                         | \$134.45 Non-Tobacco                | <b>Tier 2</b>                         | Deductible & Coinsurance                                                          |
|                                                                                                              |                         | \$173.20 Tobacco                    | <b>Tier 3</b>                         | Deductible & Coinsurance                                                          |
|                                                                                                              |                         | <u><b>Employee + Family</b></u>     | <b>Tier 4</b>                         | Deductible & Coinsurance                                                          |
|                                                                                                              |                         | \$321.32 Non-Tobacco                |                                       |                                                                                   |
|                                                                                                              |                         | \$360.07 Tobacco                    |                                       | Preventive Care, Screening, and Immunization Covered at No Charge                 |
| <b>DENTAL INSURANCE</b>                                                                                      |                         | <b>Delta Dental of SD</b>           |                                       |                                                                                   |
| <b>Base Plan</b>                                                                                             |                         |                                     | <b>Paid by Delta Dental</b>           |                                                                                   |
| Plan Year:                                                                                                   | August 1 - July 31      | <b>Employee Deduction</b>           | <b>Preventive Care</b>                | 100%                                                                              |
| Website:                                                                                                     | deltadentalsd.com       | <b>Rate Per Paycheck (48)</b>       | <b>Basic Services</b>                 | 50%                                                                               |
|                                                                                                              |                         | <u><b>Employee Only</b></u>         | <b>Major Services</b>                 | No Coverage                                                                       |
| Contact:                                                                                                     | 877-841-1478            | \$5.88                              | <b>Orthodontia</b>                    | No Coverage                                                                       |
|                                                                                                              |                         | <u><b>Employee + Spouse</b></u>     |                                       |                                                                                   |
|                                                                                                              |                         | \$11.75                             | <b>Deductible</b>                     | <b>Individual \$50</b>                                                            |
|                                                                                                              |                         | <u><b>Employee + Child(ren)</b></u> |                                       | <b>Family \$150</b>                                                               |
|                                                                                                              |                         | \$11.25                             | <b>Annual Maximum</b>                 | \$1,000 per individual                                                            |
|                                                                                                              |                         | <u><b>Employee + Family</b></u>     |                                       |                                                                                   |
|                                                                                                              |                         | \$18.00                             |                                       |                                                                                   |
| <b>Enhanced Plan</b>                                                                                         |                         |                                     | <b>Paid by Delta Dental</b>           |                                                                                   |
| Plan Year:                                                                                                   | August 1 - July 31      | <b>Employee Deduction</b>           | <b>Preventive Care</b>                | 100%                                                                              |
| Website:                                                                                                     | deltadentalsd.com       | <b>Rate Per Paycheck (48)</b>       | <b>Basic Services</b>                 | 80%                                                                               |
|                                                                                                              |                         | <u><b>Employee Only</b></u>         | <b>Major Services</b>                 | 50%                                                                               |
| Contact:                                                                                                     | 877-841-1478            | \$9.88                              | <b>Orthodontia</b>                    | 50% up to a lifetime maximum benefit of \$1,000 per individual; deductible waived |
|                                                                                                              |                         | <u><b>Employee + Spouse</b></u>     |                                       | <b>Individual \$50</b>                                                            |
|                                                                                                              |                         | \$19.50                             | <b>Deductible</b>                     | <b>Family \$150</b>                                                               |
| <b>Endodontics Periodontics, Major Services, and Orthodontic have a 12-month waiting period for coverage</b> |                         | <u><b>Employee + Child(ren)</b></u> |                                       |                                                                                   |
|                                                                                                              |                         | \$20.00                             | <b>Annual Maximum</b>                 | \$1,500 per individual                                                            |
|                                                                                                              |                         | <u><b>Employee + Family</b></u>     |                                       |                                                                                   |
|                                                                                                              |                         | \$29.25                             |                                       |                                                                                   |

| VISION INSURANCE                                                      |                  | VSP                                                          |                                              |                                                                                 |                             |                                             |
|-----------------------------------------------------------------------|------------------|--------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------|-----------------------------|---------------------------------------------|
| VSP Choice Network                                                    |                  |                                                              |                                              |                                                                                 |                             |                                             |
| Website:                                                              | vsp.com          | Employee Deduction Rate Per Paycheck (48)                    |                                              | Exam Lens Frames Contacts                                                       | Once every 12 Months        | \$10 / Up to \$60                           |
|                                                                       |                  | Employee Only                                                |                                              |                                                                                 | Once every 12 Months        | *\$25 / Basic                               |
|                                                                       |                  | \$3.35                                                       |                                              |                                                                                 | Once every 12 Months        | **\$200 Allowance                           |
|                                                                       |                  | Employee + Spouse                                            |                                              |                                                                                 | Once every 12 Months        | \$150 Allowance / in lieu of glasses        |
|                                                                       |                  | \$5.36                                                       |                                              | Lightcare                                                                       | One every 12 Months         | \$200 Allowance on non-prescription glasses |
| Contact:                                                              | 800-877-7195     | Employee + Child(ren)                                        |                                              |                                                                                 |                             |                                             |
|                                                                       |                  | \$5.47                                                       |                                              |                                                                                 |                             |                                             |
|                                                                       |                  | Employee + Family                                            |                                              |                                                                                 |                             |                                             |
|                                                                       |                  | \$8.82                                                       |                                              |                                                                                 |                             |                                             |
| *Additional charges may apply to lenses based on selection            |                  |                                                              |                                              |                                                                                 |                             |                                             |
| **Additional Discounts may apply. See Plan Summary for Details        |                  |                                                              |                                              |                                                                                 |                             |                                             |
| HEALTH SAVINGS ACCOUNT available with \$6,000 HDHP                    |                  |                                                              |                                              | Health Equity                                                                   |                             |                                             |
| Website:                                                              | healthequity.com | 2026 Contribution Limit                                      |                                              | 2027 Contribution Limits                                                        |                             |                                             |
| Contact:                                                              | 866-735-8195     | Self only                                                    | \$4,400                                      | Self only                                                                       | \$4,500                     |                                             |
|                                                                       |                  | Family                                                       | \$8,750                                      | Family                                                                          | \$9,000                     |                                             |
| FLEXIBLE SPENDING ACCOUNT                                             |                  |                                                              |                                              | Health Equity                                                                   |                             |                                             |
| Website:                                                              | healthequity.com | 2026 Contribution Limit                                      |                                              |                                                                                 |                             |                                             |
| Contact:                                                              | 866-735-8195     | Self only                                                    | \$1,500                                      | Carryover: \$500                                                                |                             |                                             |
|                                                                       |                  | Family                                                       | \$1,500                                      |                                                                                 |                             |                                             |
| DEPENDENT CARE SPENDING ACCOUNT                                       |                  |                                                              |                                              | Health Equity                                                                   |                             |                                             |
| Website:                                                              | healthequity.com | 2026 Contribution Limit                                      |                                              |                                                                                 |                             |                                             |
| Contact:                                                              | 866-735-8195     | \$7,500                                                      |                                              |                                                                                 |                             |                                             |
| VOLUNTARY SUPPLEMENTAL BENEFIT                                        |                  | Lincoln Financial                                            | Lincoln Financial                            | The Standard                                                                    | Lincoln Financial           |                                             |
| Voluntary -                                                           |                  | Accident Employee                                            | Critical Illness                             | Short Term Disability                                                           | Hospital Indemnity Employee |                                             |
| Employee Paid                                                         |                  | Low Plan: \$1.94                                             | Rates are Age Banded                         | Rates are Age Banded                                                            | Low Plan: \$4.49            |                                             |
| Rate Per Paycheck (48)                                                |                  | High Plan: \$3.50                                            |                                              |                                                                                 | High Plan: \$8.94           |                                             |
|                                                                       |                  | Employee + Spouse                                            | See your Employee Benefits Website for Rates |                                                                                 | Employee + Spouse           |                                             |
|                                                                       |                  | Low Plan: \$3.35                                             |                                              |                                                                                 | Low Plan: \$8.97            |                                             |
|                                                                       |                  | High Plan: \$6.05                                            |                                              |                                                                                 | High Plan: \$17.98          |                                             |
|                                                                       |                  | Employee + Child (ren)                                       |                                              |                                                                                 | Employee + Child (ren)      |                                             |
|                                                                       |                  | Low Plan: \$5.13                                             |                                              |                                                                                 | Low Plan: \$6.41            |                                             |
|                                                                       |                  | High Plan: \$9.05                                            |                                              |                                                                                 | High Plan: \$12.78          |                                             |
|                                                                       |                  | Family                                                       |                                              |                                                                                 | Family                      |                                             |
|                                                                       |                  | Low Plan: \$6.41                                             |                                              |                                                                                 | Low Plan: \$11.18           |                                             |
|                                                                       |                  | High Plan: \$11.87                                           |                                              |                                                                                 | High Plan: \$22.36          |                                             |
| GROUP TERM & VOLUNTARY LIFE                                           |                  |                                                              | Lincoln Financial                            |                                                                                 |                             |                                             |
| Group Life & AD&D Insurance - First of the Month Following 60 Days    |                  | Employer paid                                                | \$15,000                                     |                                                                                 |                             |                                             |
| Voluntary Group Term Life & AD&D First of the Month Following 60 Days |                  | Employee paid Rates are Age Banded                           | Employee                                     | Increments of \$10,000 up to \$500,000 – not to exceed 5X Annual Earnings       |                             |                                             |
|                                                                       |                  | See your Employee Benefits Website for Rates                 | Guaranteed Issue                             | \$100,000                                                                       |                             |                                             |
|                                                                       |                  |                                                              | Spouse                                       | Increments of \$5,000 up to \$250,000 – not to exceed 50% of Employee coverage. |                             |                                             |
|                                                                       |                  |                                                              | Guaranteed Issue                             | \$25,000                                                                        |                             |                                             |
|                                                                       |                  |                                                              | Child(ren)                                   | 14 Days to 6 Months - \$250                                                     |                             |                                             |
|                                                                       |                  |                                                              |                                              | 6 Months to Age 19 (25 if Full Time Student) - \$10,000                         |                             |                                             |
| 401K RETIREMENT PLAN – Empower                                        |                  |                                                              |                                              |                                                                                 |                             |                                             |
| Enrollment dates:                                                     |                  | Eligible the first of the month after 180 days of employment |                                              |                                                                                 |                             |                                             |

This is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions. Actual monthly and annual premium amounts may vary due to fluctuations in the enrollment counts and/or ages of covered persons over the previous and next year.