

2025 Salaried 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 8/01/2025 to 7/31/2026.

Type of Benefit		Deduction	Plan Information	
MEDICAL INSURANCE		Wellmark		
\$4,000 PPO Plan				
Deductible:	January 1 - December 31	Employee Deduction	Deductible: Single / Family	\$4,000 / \$8,000
Plan Year:	8/1/2025	Rate Per Paycheck (24)	Coinsurance	50% Wellmark
Website:	wellmark.com	<u>Employee Only</u>		50% Member
Contact:	800-524-9242	\$142.20 Non- Tobacco	Out of Pocket: Single / Family	\$8,000 / \$16,000
		\$202.20 Tobacco	Office Visit	Primary Care \$25 Copay
		<u>Employee + Spouse</u>		Specialty Care \$75 Copay
		\$425.83 Non-Tobacco		Telehealth \$0
Spousal Surcharge of \$100 Monthly apply if spouse has access to other coverage.		\$503.33 Tobacco	Prescription Drug:	
		<u>Employee + Child(ren)</u>	Tier 1 - Generics	\$0 Copay
		\$369.39 Non- Tobacco	Tier 2	25% up to \$200
		\$446.89 Tobacco	Tier 3	50% up to \$200
		<u>Employee + Family</u>	Tier 4	Deductible & Coinsurance
		\$797.43 Non- Tobacco		
		\$874.93 Tobacco		Preventive Care, Screening and Immunizatin Covered at No Charge
\$4,750 PPO Plan				
Deductible:	January 1 - December 31	Employee Deduction	Deductible: Single / Family	\$4,750 / \$9,500
Plan Year:	8/1/2025	Rate Per Paycheck (24)	Coinsurance	50% Wellmark
Website:	wellmark.com	<u>Employee Only</u>		50% Member
Contact:	800-524-9242	\$137.53 Non-Tobacco	Out of Pocket: Single / Family	\$9,100 / \$16,200
		\$197.53 Tobacco	Office Visit	Primary Care \$35 Copay
		<u>Employee + Spouse</u>		Specialty Care \$80 Copay
		\$411.87 Non-Tobacco		Telehealth \$0
Spousal Surcharge of \$100 Monthly apply if spouse has access to other coverage.		\$489.37 Tobacco	Prescription Drug:	
		<u>Employee + Child(ren)</u>	Tier 1 - Generics	\$0 Copay
		\$357.28 Non-Tobacco	Tier 2	25% up to \$150
		\$434.78 Tobacco	Tier 3	50% up to \$150
		<u>Family</u>	Tier 4	Deductible & Coinsurance
		\$711.28 Non-Tobacco		
		\$848.78 Tobacco		Preventive Care, Screening and Immunizatin Covered at No Charge
\$6,000 HDHP				
Deductible:	January 1 - December 31	Employee Deduction	Deductible: Single / Family	\$6,000 / \$12,000
Plan Year:	8/1/2025	Rate Per Paycheck (24)	Coinsurance	80% Wellmark
Website:	wellmark.com	<u>Employee Only</u>		20% Member
Contact:	800-524-9242	\$74.98 Non-Tobacco	Out of Pocket: Single / Family	\$7,500 / \$15,000
		\$107.48 Tobacco	Office Visit	Primary Care Deductible & Coinsurance
		<u>Employee + Spouse</u>		Specialty Care Deductible & Coinsurance
Spousal Surcharge of \$100 Monthly apply if spouse has access to other coverage.		\$317.34 Non-Tobacco		Telehealth Deductible & Coinsurance
		\$394.84 Tobacco	Prescription Drug:	
		<u>Employee + Child(ren)</u>	Tier 1 - Generics	Deductible & Coinsurance
		\$268.89 Non-Tobacco	Tier 2	Deductible & Coinsurance
		\$346.39 Tobacco	Tier 3	Deductible & Coinsurance
		<u>Employee + Family</u>	Tier 4	Deductible & Coinsurance
		\$642.64 Non-Tobacco		
		\$720.14 Tobacco		Preventive Care, Screening and Immunizatin Covered at No Charge
DENTAL INSURANCE		Delta Dental of SD		
Base Plan			Paid by Delta Dental	
Plan Year:	August 1 - July 31	Employee Deduction	Preventive Care	100%
Website:	deltadentalsd.com	Rate Per Paycheck (24)	Basic Services	50%
		<u>Employee Only</u>	Major Services	No Coverage
		\$11.75	Orthodontia	No Coverage
Contact:	877-841-1478	<u>Employee + Spouse</u>		
		\$23.50	Deductible	Individual \$50
		<u>Employee + Child(ren)</u>		Family \$150
		\$22.50	Annual Maximum	\$1,000 per individual
		<u>Employee + Family</u>		
		\$36.00		
Enhanced Plan			Paid by Delta Dental	
Plan Year:	August 1 - July 31	Employee Deduction	Preventive Care	100%
Website:	deltadentalsd.com	Rate Per Paycheck (24)	Basic Services	80%
		<u>Employee Only</u>	Major Services	50%
		\$19.75	Orthodontia	50% up to a lifetime maximum benefit of \$1,000 per individual; deductible waived
Contact:	877-841-1478	<u>Employee + Spouse</u>		Individual \$50
		\$39.00	Deductible	Family \$150
Endodontics Periodontics, Major Services, and Orthodontic have a 12-month waiting period for coverage		<u>Employee + Child(ren)</u>		
		\$40.00	Annual Maximum	\$1,500 per individual
		<u>Employee + Family</u>		
		\$58.50		

VISION INSURANCE		VSP			
VSP Choice Network					
Website: vsp.com		Employee Deduction Rate Per Paycheck (24) <u>Employee Only</u> \$6.70 <u>Employee + Spouse</u> \$10.72 <u>Employee + Child(ren)</u> \$10.94 <u>Employee + Family</u> \$17.64	Exam Lens Frames Contacts	Once every 12 Months Once every 12 Months Once every 12 Months Once every 12 Months	\$10 / Up to \$60 *\$25 / Basic **\$200 Allowance \$150 Allowance / in lieu of glasses
Contact: 800-877-7195					*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		2025 Contribution Limit	2026 Contribution Limits		Plan Year August -July
Contact: 866-735-8195		Self only \$4,300 Family \$8,550	Self only \$4,400 Family \$8,750		
FLEXIBLE SPENDING ACCOUNT			Health Equity		
Website: healthequity.com		2025 Contribution Limit			
Contact: 866-735-8195		Self only \$1,500 Family \$1,500			Carryover: \$500
DEPENDENT CARE SPENDING ACCOUNT			Health Equity		
Website: healthequity.com		2025 Contribution Limit			
Contact: 866-735-8195		\$5,000			
VOLUNTARY SUPPLEMENTAL BENEFIT					
Voluntary - Employee Paid Rate Per Paycheck (24)		Accident <u>Employee</u> Plan 1: \$3.87 Plan 2: \$7.00 <u>Employee + Spouse</u> Plan 1: \$6.69 Plan 2: \$12.10 <u>Employee + Child (ren)</u> Plan1: \$10.25 Plan 2: \$18.09 <u>Family</u> Plan1: \$12.81 Plan 2: \$23.74	Critical Illness Rates are Age Banded <u>See your Employee Benefits Website for Rates</u>	Allstate Short Term Disability Rates are Age Banded	Hospital Indemnity <u>Employee</u> Plan 1: \$8.97 Plan 2: \$17.88 <u>Employee + Spouse</u> Plan 1: \$17.94 Plan 2: \$35.95 <u>Employee + Child (ren)</u> Plan1: \$12.81 Plan 2: \$25.55 <u>Family</u> Plan1: \$22.36 Plan 2: \$44.72
GROUP TERM & VOLUNTARY LIFE AND LTD			Lincoln Financial		
Group Life & AD&D Insurance - First of the Month Following 60 Days		Employer paid	\$50,000		
Voluntary Group Term Life & AD&D First of the Month Following 60 Days		Employee paid Rates are Age Banded <u>See your Employee Benefits Website for Rates</u>	Employee Guaranteed Issue Spouse Guaranteed Issue Child(ren)	Increments of \$10,000 up to \$500,000 – not to exceed 5 x's Annual Earnings \$100,000 Increments of \$5,000 up to \$250,000 – not to exceed 50% of Employee coverage. \$25,000 14 Days to 6 Months - \$250 6 Months to Age 19 (25 Full Time Student) - \$10,000	
Long-Term Disability (LTD) First of the Month Following 60 Days		Employer Paid	Elimination Period: 90 Days Benefit Duration: Later of Age 65 or Social Security Normal Maximum Monthly Benefit Amount: \$10,000		
401K RETIREMENT PLAN – Fidelity Investments					
Enrollment dates:		• Employees automatically enrolled at 2% • Auto-increase 1%/year up to 5%			
Website:					
Contact:					

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.