EMPLOYEE BENEFITS 2018

OVERVIEW

Five Star Equipment provides a very competitive health insurance benefit through Highmark BCBS to its employees. We have worked very hard to limit premium increases and employee cost share. Employee portion of his/her health insurance is as follows:

PPO BLUE W/Rx	EMPLOYER BI-WEEKLY COST	EMPLOYEE BI-WEEKLY COST
Individual	$289.30	$53.40
Parent & Child	$453.64	$83.74
Parent & Children	$645.16	$119.10
Two Person	$645.74	$119.20
Family	$815.86	$150.60

Employer-funded **Health Reimbursement Account** with Highmark, **$1,750** per year per participant for up to 3 participants ($5,250 maximum annual employer contribution). For single coverage, this contribution in effect reduces the $2,000 in-network deductible to **$250**.

LIFE INSURANCE

The company covers each employee with a $50,000 life insurance policy during their employment. Additional insurance can be purchased by employee at group rates.

401(K) PLAN

A 401(k) Plan with Massachusetts Mutual Life Insurance Company is available for all employees to participate in after 30 days of service. This is tax deferrable and Five Star Equipment will match **50% percent of employee contribution up to 4 percent.**

You will be **automatically** enrolled and **4%** of your pay will be withheld from each paycheck and deposited into the Plan.

- All participants who are contributing less than 10% of pay will be automatically increased 1% each January 1st unless they make an affirmative election to opt out or change the amount of their contribution.
- You may elect to opt out of the automatic increases by accessing your account online or calling MassMutual: **1 (800) 743-5274**
- MassMutual website: **www.Retiresmart.com**

VACATION & PERSONAL TIME

	IN THE YEAR (HIRED)									
Hire Date	**1/1–1/31**	**2/1–2/29**	**3/1–3/31**	**4/1–4/30**	**5/1–5/31**	**6/1–6/30**	**7/1–7/31**	**8/1–8/31**	**9/1–9/30**	**10/1–12/31**
# of Days	9	8	7	6	5	4	3	2	1	0
# of Hours	72	64	56	48	40	32	24	16	8	0

TOTAL LENGTH OF SERVICE	0–5 YEARS	6–10 YEARS	AFTER 10 YEARS
***Days Awarded on January 1**	—	—	—
Total Vacation Days for the Calendar Year:	10	15	20
Total Vacation Hours for the Calendar Year:	80	120	160

Vacation may not be accumulated from year to year. Personal Time may be carried over from year to year not to exceed 15 days.

VOLUNTARY DENTAL AND VISION

Employee paid plans, group rated, are available through Five Star Equipment, Inc.

BENEFIT	DENTAL BI-WEEKLY COST		VISION BI-WEEKLY COST
	The Guardian Low Plan	**The Guardian High Plan**	**Vision Benefits of America**
Employee	$8.46	$13.01	$3.81
Employee & Children	$25.27	$35.55	—
Employee & Spouse / 2 Person	$20.65	$29.36	$6.65
Family	$37.46	$51.90	$9.51

FIVE STAR EQUIPMENT 2018

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

BENEFIT	IN NETWORK	OUT OF NETWORK
General Provisions		
BENEFIT PERIOD(1)	CONTRACT YEAR	
Deductible (per benefit period)		
Individual	$2,000	$5,000
Family	$6,000	$15,000
Plan Pays – Payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	$15,000
Family	None	$45,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	$7,350	Not Applicable
Family	$14,700	Not Applicable
Office / Clinic / Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $15 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	50% after deductible
Urgent Care Center Visits	100% after $30 copay	50% after deductible
Telemedicine Services (3)	100% after $10 copay	Not Covered
Preventive Care (4)		
ROUTINE ADULT **Physical Exams**	100% (deductible does not apply)	50% after deductible
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
ROUTINE PEDIATRIC **Physical Exams**	100% (deductible does not apply)	50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	100% (deductible does not apply) for emergencies; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergencies; 50% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including Maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Maternity (Non-Preventive Facility & Professional Services) including Dependent Daughter	100% after deductible	50% after deductible
Medical Care (including Inpatient Visits and Consultations)/ Surgical Expenses	100% after deductible	50% after deductible

BENEFIT	IN NETWORK	OUT OF NETWORK
Therapy and Rehabilitation Services		
Physical Medicine	100% after $30 copay	50% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	50% after deductible
Speech Therapy	100% after $30 copay	50% after deductible
	Limit: 12 visits/benefit period	
Occupational Therapy	100% after $30 copay	50% after deductible
	Limit: 12 visits/benefit period	
Spinal Manipulations	100% after $30 copay	50% after deductible
	Limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	50% after deductible
Outpatient Substance Abuse Services	100% after deductible	50% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	50% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100% after deductible	50% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination — 3 attempts per lifetime)	100% after deductible	50% after deductible
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
DIAGNOSTIC SERVICES **Advanced Imaging (MRI, CAT, PET scan, etc.)**	100% after $75 copay	50% after deductible
Basic Diagnostic Services (Standard Imaging, Diagnostic Medical, Lab/Pathology, Allergy Testing)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	50% after deductible
Private Duty Nursing	Not Covered	Not Covered
Skilled Nursing Facility Care	100% after deductible	50% after deductible
	Limit: 60 days/benefit period	
Transplant Services	100% after deductible	50% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program (8) Soft Mandatory Generic **Defined by the National Pharmacy Network - Not Physician Network.** **Prescriptions filled at a non-network pharmacy are not covered.** **Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.**	RETAIL DRUGS (31/60/90-DAY SUPPLY) $3 / $6 / $9 non-formulary low cost generic copay $10 / $20 / $30 Formulary generic copay $30 / $60 / $90 Formulary brand copay $55 / $110 / $165 Non-Formulary brand copay MANDATORY MAIL ORDER — ACTIVE CHOICE MAINTENANCE DRUGS THROUGH MAIL ORDER (90-DAY SUPPLY) $6 Formulary low cost generic copay $6 Non-Formulary low cost generic copay $20 Formulary generic copay $20 Non-Formulary generic copay $60 Formulary brand copay $110 Non-Formulary brand copay	