



Employee Benefits: January 1, 2023 to December 31, 2023

The following information is offered as a summary only. If there is a discrepancy between this information and the plan document, the plan document will govern. All benefits outlined are based on a full time 30 hours per week status. Employees will be eligible for benefits 1st of the month following 60 days of hire. All deductions are calculated on a bi-weekly basis. For more information, please contact our benefits adviser, The CIP Group at (617) 354-0866, Option 2.



Health Insurance

In-Network Benefits

Kids & Company offers three medical plan options through United Health Care. Employees can choose either Core 3000, Core 1500, or Core H.S.A. 3000 medical plans. Please review the SBC (Summary of Benefit & Coverage) for further plan details.

Type of Service	Choice Plus 3000	Choice Plus 1500	Choice Plus H.S.A. 3000
Individual Deductible	\$3,000	\$1,500	\$3,000
Family Deductible	\$6,000	\$3,000	\$6,000
Preventive Office Visits	\$0	\$0	\$0
Non-Preventive Physician Visits	PCP: \$30 Specialist: Tier 1: \$30, Tier 2: \$60	PCP: \$20 Specialist: Tier 1: \$20, Tier 2: \$40	PCP & Specialist: 20% after deductible
X-rays, Lab tests	X-Ray: \$0 Labs: \$0 after deductible	X-Ray: \$0 Labs: \$0 after deductible	X-Ray & Labs: 20% after deductible
MRI's, CT scans, PET scans	20% after deductible	10% after deductible	20% after deductible
Routine Eye Exam	\$0	\$0	20% after deductible
Emergency	\$250 than 20% coinsurance	\$250 than 10% coinsurance	20% after deductible
Day Surgery	20% after deductible	10% after deductible	20% after deductible
Hospitalization	20% after deductible	10% after deductible	20% after deductible
Mental Health	\$30	\$20	20% after deductible
Prescription	\$10/\$40/\$75/\$125	\$10/\$40/\$75/\$125	Deductible applies first, then: \$10/\$35/\$60
Out of Pocket Maximum	Ind: \$6,000/Fam: \$12,000	Ind: \$3,000/Fam: \$6,000	Ind: \$6,350/Fam: \$12,700
Plan Tier	Bi-Weekly Payroll Deductions		
Individual (Employee Only)	\$105.22	\$125.21	\$57.59
Individual + Spouse	\$188.36	\$224.14	\$103.10
Individual + Child(ren)	\$196.25	\$233.53	\$107.42
Family Rates	\$279.38	\$332.45	\$152.92

Ind = Employee Only

Fam = Family, Employee + Spouse, Employee + Child(ren)

Out-of-Network Benefits

Benefits are available outside of the United Health Care Network. Additional coinsurance and deductibles apply. Please see Summary of Benefits for further information.

Type of Service	Choice Plus 3000	Choice Plus 1500	Choice Plus H.S.A. 3000
Individual Deductible	\$5,000	\$5,000	\$5,000
Family Deductible	\$10,000	\$10,000	\$10,000
Preventive Office Visits	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Non-Preventive Physician Visits	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
X-rays, Lab tests	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
MRI's, CT scans, PET scans	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Routine Eye Exam	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Emergency	\$250 than 20% coinsurance	\$250 than 10% coinsurance	20% after deductible
Day Surgery	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Hospitalization	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Mental Health	40% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible
Prescription	\$10/\$40/\$75/\$125	\$10/\$40/\$75/\$125	Deductible applies first, then: \$10/\$35/\$60
Out of Pocket Maximum	Ind: \$10,000/Fam: \$20,000	Ind: \$10,000/Fam: \$20,000	Ind: \$10,000/Fam: \$20,000

Ind = Employee Only
Fam = Family, Employee + Spouse, Employee + Child(ren)

Type of Service	Plan Covers	
	In-Network	Out-of-Network
Type I: Preventative	100%	100%
<ul style="list-style-type: none"> Cleanings, Oral Exams X-Rays, Films, Sealants Space Maintainers 		
Type II: Basic	80% after deductible*	80% after deductible*
<ul style="list-style-type: none"> Basic Restorative Resin-based composite restorations Non-Surgical Extractions Removal of erupted tooth or exposed root Root Canal Endodontics & Periodontics 		
Type III: Major	50% after deductible*	50% after deductible*
<ul style="list-style-type: none"> Crowns, Bridges, Dentures 		
Plan Maximum Benefit	\$1,500 per person per calendar year	
*Deductible Applies	Individual: \$50 Family: \$150	
Plan Tier	Bi-Weekly Payroll Deductions	
Individual	\$17.29	
Individual + Spouse	\$34.98	
Individual + Child(ren)	\$42.04	
Family	\$64.32	

Type of Service	In-Network	Out-Of-Network
Vision Care Services		
<ul style="list-style-type: none"> Exam with dilation as necessary Contact lens fit and follow-up 	<p>Up to \$30</p> <p>N/A</p>	<p>Up to \$30</p> <p>N/A</p>
Frames:		
Any available frame at provider location	\$0 copay, \$100 allowance, 20% off balance over \$100	Up to \$50
Standard Lenses		
<ul style="list-style-type: none"> Single Bifocal Trifocal Lenticular Standard progressive lens Premium progressive lens (tiers 1-3) 	<p>\$25 copay</p> <p>\$25 copay</p> <p>\$25 copay</p> <p>\$25 copay</p> <p>\$90 copay</p> <p>See table on carrier Benefit Summary</p>	<p>Up to \$25</p> <p>Up to \$40</p> <p>Up to \$55</p> <p>Up to \$55</p> <p>Up to \$40</p> <p>Up to \$40</p>
Contact Lenses		
<ul style="list-style-type: none"> Conventional Disposable Medically Necessary 	<p>\$0 copay, \$100 allowance, 15% off balance over \$100</p> <p>\$0 copay, \$100 allowance, plus balance over \$100</p> <p>\$0 copay, paid-in-full</p>	<p>Up to \$80</p> <p>Up to \$80</p> <p>Up to \$210</p>
Frequency		
<ul style="list-style-type: none"> Exam Lenses or contact lenses Frame Contact lens eval/fitting 	<p>Once every 12 months</p> <p>Once every 12 months</p> <p>Once every 12 months</p> <p>N/A</p>	
Plan Tier	Bi-Weekly Payroll Deductions	
Individual	\$2.86	
Individual + Spouse	\$5.43	
Individual + Child(ren)	\$5.71	
Family	\$8.40	

Kids & Company offers Group Life & AD&D insurance through Dearborn Group. Benefit is 100% Employer paid and there is no cost to the employees. Employees are able to purchase additional Life Insurance, Short-Term Disability and Long-Term Disability benefits that are 100% employee paid. Please review the benefit summary for plan details.

Employer Paid Life & AD&D Insurance	
Benefit	\$50,000
Age Reduction	Benefits reduce by 35% of the original amount at age 65; and further reduce by 50% of the original amount at age 70
Bi-Weekly Payroll Deductions	
N/A – No Cost to Employees (100% paid by Kids & Company)	

Voluntary Life, Short-Term & Long-Term Disability

Voluntary Life & AD&D Insurance	
Employee Life Benefit	Increments of \$10,000 up to \$500,000 Evidence of Insurability required over \$50,000
Spouse Life Benefit	Increments of \$5,000 up to \$100,000 Not to exceed 50% of Employee Voluntary Life Amount Evidence of Insurability required over \$25,000
Child Life Benefit	Age 15 days – 6 months: \$100 Age 6 months – 26 years: Increments of \$1,000 up to \$10,000
Life Benefit Age Reduction	65% at age 70, 45% at age 75
Voluntary Short-Term Disability	
Benefit	\$100-\$1,000 in increments of \$50 not to exceed 60% of basic weekly earnings
Duration	13 Weeks or until LTD begins, whichever is earlier
Benefit Waiting Period <i>When benefits start</i>	1 st day for accident and 8 th day for sickness
Voluntary Long-Term Disability	
Benefit	60% salary up to \$6,000 per month
Benefit Waiting Period <i>When benefits start</i>	90 Days
Maximum Period Payable	5 year reducing benefit duration
Bi-Weekly Payroll Deductions – Rates in ADP	
Voluntary Life	100% Employee Paid
Voluntary STD	100% Employee Paid
Voluntary LTD	100% Employee Paid

IMPORTANT INSURANCE PREMIUM NOTICE:

By electing to enroll in benefits, you understand that your contributions to the group medical, dental, and vision coverage will be taken on a pre-tax basis. You also understand that you are making a binding election concerning your benefits and authorizing payroll deductions. In the event that Kids & Company is unable to deduct these amounts, it is your obligation to pay these amounts to Kids & Company in the form of a check by the first of the month following missed deductions. You understand that an outstanding balance may lead to termination of insurance back to the last payment date.

Kids & Company - Benefit Elections

EMPLOYEE INFORMATION:

Employee First Name _____ Employee Last Name: _____

Employee Date of Birth: _____ Employee SSN: _____

Employee Address: _____ City: _____

State: _____ ZIP Code: _____

Employee Gender: _____ Employee Phone Number: _____

Employee Email Address: _____

Employee PCP Full Name: _____ Employee PCP Town: _____

Hire Date: _____ Hourly Rate or Salary: _____

DEPENDENT INFORMATION:

Spouse:

First Name: _____ Last Name: _____ DOB: _____

SSN: _____ Gender: _____ PCP Full Name: _____

Spouse Address (If different): _____

Dependent 1

First Name: _____ Last Name: _____ DOB: _____

SSN: _____ Gender: _____ PCP Full Name: _____

PCP Town: _____

Dependent 2

First Name: _____ Last Name: _____ DOB: _____

SSN: _____ Gender: _____ PCP Full Name: _____

PCP Town: _____

Dependent 3

First Name: _____ Last Name: _____ DOB: _____

SSN: _____ Gender: _____ PCP Full Name: _____

PCP Town: _____

Dependent 4

First Name: _____ Last Name: _____ DOB: _____

SSN: _____ Gender: _____ PCP Full Name: _____

PCP Town: _____

Kids & Company - Benefits Elections:

UHC Medical (Check One): Enroll: Waive:

Tier (Check One): Employee Employee + Spouse: Employee + Child(ren): Family:

UHC Plan: **Choice Plus 1500:** **Choice Plus 3000:** **Choice Plus 3000 HSA:**

UHC Dental (Check One): Enroll: Waive:

Tier (Check One): Employee Employee + Spouse: Employee + Child(ren): Family:

Dearborn Vision (Check One): Enroll: Waive:

Tier (Check One): Employee Employee + Spouse: Employee + Child(ren): Family:

Life Insurance: Enroll: (Employer Paid)

Additional Life Insurance*: Enroll: Amount: _____

Short Term Disability*: Enroll: Amount: _____

Long Term Disability*: Enroll: Amount: _____

*Evidence of Insurability may be required.

Sign: _____ Date: _____

IMPORTANT INSURANCE PREMIUM NOTICE:

By electing to enroll in benefits, you understand that your contributions to the group medical, dental, and vision coverage will be taken on a pre-tax basis. You also understand that you are making a binding election concerning your benefits and authorizing payroll deductions. In the event that Kids & Company is unable to deduct these amounts, it is your obligation to pay these amounts to Kids & Company in the form of a check by the first of the month following missed deductions. You understand that an outstanding balance may lead to termination of insurance back to the last payment date.