Bates

Medical and Pharmacy In-Network Only Benefit Comparison

January 1, 2024 - December 31, 2024 Plan Year

Aetna Plan Options	Consumer Choice (HSA)	Whole Health (ACO)		PPO
Contributions				
Employee Contributions (FT)	**Per Month**	**Per Month**		**Per Month**
Employee Only	$39.17	$108.98		$126.18
Employee & Spouse / DP	$292.08	$433.59		$469.16
Employee & Child(ren)	$232.77	$370.51		$401.47
Family	$459.95	$672.18		$724.94
Bates' HSA Base Contribution	Paid in 3 installments	Not Available		Not Available
Single	$600			
Family	$1,200			
Bates' HSA Additional Contribution	50% match up to	Not Available		Not Available
Single / Family	$300 / $600			
Medical Coverage		**Tier 1**	**Tier 2**	
Annual Deductible	Embedded	Embedded	Embedded	Embedded
Single / Family	$3,200 / $6,400	$250 / $500	$2,000 / $4,000	$1,250 / $2,500
Coinsurance	20%	20%	40%	20%
Annual Out-of-Pocket Maximum	Embedded	Embedded	Embedded	Embedded
Single / Family	$3,700 / $7,400	$1,500 / $3,000	$4,000 / $8,000	$3,000 / $6,000
Embedded Definition	The family deductible and out-of-pocket maximum can be met by any combination of family members, but no single individual within the family will be subject to more than the individual deductible and individual out-of-pocket maximum.			
Preventive Care - *Please see the detailed plan summary for age and frequency limitations.*				
Routine Adult Physical / Immunization	Covered at 100% Deductible Waived	Covered at 100% Deductible Waived		Covered at 100% Deductible Waived
Routine Well-Child Exam / Immunization				
Routine Well-Woman Exam				
Routine Eye Exam				

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Medical Coverage		**Tier 1**	**Tier 2**	
Mental Health Services				
Inpatient	20% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible
Outpatient	20% after Deductible	$25 Copay	$45 Copay	$35 Copay
Substance Abuse Services				
Inpatient	20% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible
Outpatient	20% after Deductible	$25 Copay	$45 Copay	$35 Copay
Family Planning - *Please see detailed plan summary for daily limits and additional services.*				
Infertility Treatment	20% after Deductible	Based on facility and service		Based on facility & service
Tubal Ligation	Covered at 100%	Covered at 100%		Covered at 100%
Vasectomy	20% after Deductible	Based on facility and service		Based on facility & service
Other Services - *Please see detailed plan summary for daily limits and additional services.*				
Spinal Manipulation Therapy	20% after Deductible	$25 Copay	$45 Copay	$35 Copay
Autism Therapy	20% after Deductible	$25 Copay	$45 Copay	$35 Copay
Acupuncture *(limited to 20 visits per year)*	20% after Deductible	$25 Copay	$45 Copay	$35 Copay
Durable Medical Equipment	20% after Deductible	Covered at 100%		Covered at 100%
Diabetic Supplies *(if not covered by Rx)*	20% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible
Temporomandibular Joint Disease (TMJ)	20% after Deductible	Not Covered		20% after Deductible
Flu Shot	Covered at 100% *at any retail flu clinic*	Covered at 100% *at your PCP*		Covered at 100% *at any retail flu clinic*

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Medical Coverage		**Tier 1**	**Tier 2**	
Office Visits				
Primary Care	20% after Deductible	$20 Copay	$40 Copay	$25 Copay
Specialist	20% after Deductible	$25 Copay	$45 Copay	$35 Copay
Walk-in Clinics	20% after Deductible	$20 Copay	$40 Copay	$25 Copay
Urgent Care	20% after Deductible	$25 Copay	$100 Copay	$25 Copay
Emergency Room (ER)	20% after Deductible	$125 Copay *Copay waived if admitted*		$125 Copay *Copay waived if admitted*
Non-Emergency treated in ER	Not Covered	Not Covered		Not Covered
Teladoc General Health Consultation	20% after Deductible up to a max Copay of $49[1]	Covered at 100%		Covered at 100%
Diagnostic Procedures				
Lab and X-Ray	20% after Deductible	Covered at 100%	40% after Deductible	Covered at 100%
Outpatient Complex Imaging *(MRI, CT Scan, PET Scan)*	20% after Deductible	$50 Copay	40% after Deductible	$50 Copay
Hospital Benefits				
Inpatient Hospital	20% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible
Hospital Indemnity Plan	Included Automatically	Available for Purchase		Available for Purchase
	Provides a $1,000 benefit to any covered member who is admitted[2] to the hospital for an inpatient hospital stay. This benefit includes your stay in an observation unit as the result of an illness or accidental injury. This benefit is limited to one payment per calendar year, per enrolled member. Funds can be used to cover the deductible or other out-of-pocket expenses; additional benefits apply.			
Outpatient Hospital	20% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible
Outpatient Surgery	20% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible

[1]Mental Health and Dermatology visits are also provided through Teladoc. Please refer to the 2023 Benefits Guidebook for pricing information for these additional services.

[2]Please refer to the Hospital Indeminity Plan brochure for the definition of admission. An overnight hospital stay without being admitted by the hospital does not qualify for the $1,000 benefit.

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Pharmacy Coverage		**Tier 1**	**Tier 2**	
Retail | 30-Day Supply	Certain preventive medications are covered ate 100% and are not subject to the deductible. All other medications are covered at 100% after the deductible.			
Generic		$10 Copay		$10 Copay
Brand Formulary		$25 Copay		$35 Copay
Brand Non-Formulary		$40 Copay		$50 Copay
Specialty		$40 Copay		$75 Copay
Mail Order | 90-Day Supply				
Generic		$20 Copay		$20 Copay
Brand Formulary		$50 Copay		$70 Copay
Brand Non-Formulary		$80 Copay		$100 Copay
Specialty		$80 Copay		$150 Copay
Fertility Drugs	Oral and injectable	Oral only		Oral and injectable
Performance Enhancing Drugs	Covered	Covered		Covered

This chart summarizes the benefits provided under the Aetna medical benefit options. For more detailed information, please refer to the formal plan documents. In the event of a discrepancy, the formal plan documents will govern.