Bates

Medical and Pharmacy In-Network Only Benefit Comparison

January 1, 2026 – December 31, 2026

Aetna Plan Options	Consumer Choice (HSA)	PPO
Contributions		
Employee Contributions (FT) Employee Only Employee + Spouse / DP Employee + Child(ren) Family	Per Month $43 $316 $252 $498	Per Month $142 $528 $452 $815
Bate's HSA Base Contribution Single Family	Paid in 3 installments $600 $1,200	Not Available
Bate's HSA Additional Contribution Single / Family	50% match up to $300 / $600	Not Available
Medical Coverage		
Annual Deductible Single / Family	Embedded $3,400 / $6,800	Embedded $1,250 / $2,500
Coinsurance	20%	20%
Annual Out-of-Pocket Maximum Single / Family	Embedded $3,900 / $7,800	Embedded $3,500 / $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.	
Preventative 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
Routine Well-Child Exam / Immunization	Covered at 100% Deductible Waived	Covered at 100% Deductible Waived
Routine Well-Women Exam	Covered at 100% Deductible Waived	Covered at 100% Deductible Waived
Routine Eye Exam	Covered at 100% Deductible Waived	Covered at 100% Deductible Waived

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Aetna Plan Options	Consumer Choice (HSA)	PPO
Medical Coverage		
Mental Health Services		
Inpatient	20% after Deductible	20% after Deductible
Outpatient	20% after Deductible	$35 Copay
Substance Abuse Services		
Inpatient	20% after Deductible	20% after Deductible
Outpatient	20% after Deductible	$35 Copay
Family Planning	*Please see detailed plan summary for daily limits and additional services.*	
Infertility Treatment	20% after Deductible	Based on facility & service
Tubal Ligation	Covered at 100%	Covered at 100%
Vasectomy	20% after Deductible	Based on facility & service
Other Services	*Please see detailed plan summary for daily limits and additional services.*	
Spinal Manipulation	20% after Deductible	$35 Copay
Autism Therapy	20% after Deductible	$35 Copay
Acupuncture	20% after Deductible	$35 Copay
Durable Medical Equipment	20% after Deductible	Covered at 100%
Diabetic Supplies (if not covered by Rx)	20% after Deductible	20% after Deductible
Temporomandibular Joint Disease (TMJ)	20% after Deductible	20% after Deductible
Flu Shot	Coved at 100% at any retail flu clinic	Covered at 100% at any retail flu clinic

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Aetna Plan Options	Consumer Choice (HSA)	PPO
Medical Coverage		
Office Visits		
Primary Care	20% after Deductible	$25 Copay
Specialist	20% after Deductible	$35 Copay
Walk-in Clinics	20% after Deductible	$25 Copay
Urgent Care	20% after Deductible	$25 Copay
Emergency Room (ER)	20% after Deductible	$125 Copay *Copay waived if admitted*
Non-Emergency treated in ER	Not Covered	Not Covered
Teladoc General Health Consultation	20% after Deductible up to a max Copay of $49*	Covered at 100%
Diagnostic Procedures		
Lab and X-Ray	20% after Deductible	Covered at 100%
Outpatient Complex Imaging (MRI, CT Scan, PET Scan)	20% after Deductible	$50 Copay
Hospital Benefits		
Inpatient Hospital	20% after Deductible	20% after Deductible
Hospital Indemnity Plan	Included Automatically	Available for purchase
	Provides a $1,000 benefit to any covered member who is admitted** 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
Outpatient Surgery	20% after Deductible	20% after Deductible

*Mental Health and Dermatology visits are also provided through Teladoc. Please refer to the 2026 Benefits Guidebook for pricing information for these additional Services.

**Please refer to the Hospital Indemnity 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.

Bates

Medical and Pharmacy In-Network Only Benefit Comparison

January 1, 2026 – December 31, 2026

Aetna Plan Options	Consumer Choice (HSA)	PPO
Pharmacy Coverage		
Retail | 30-Day Supply Generic Brand Formulary Brand Non-Formulary Specialty	Certain preventive medications are covered at 100% and are not subject to the deductible. All other medications are covered at 100% after the deductible.	 $10 Copay $35 Copay $50 Copay $75 Copay
Mail Order | 90-Day Supply Generic Brand Formulary Non-Brand Formulary Specialty	Certain preventive medications are covered at 100% and are not subject to the deductible. All other medications are covered at 100% after the deductible.	 $20 Copay $70 Copay $100 Copay $150 Copay
Fertility Drugs	Oral and injectable are covered	Oral and injectable are covered
Performance Enhancing Drugs	Covered	Covered

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