Augusta Health | HR Benefits

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2026 Augusta Health Medical Benefit Options Side-by-Side

This document provides a high-level overview. For a complete list of services and detailed coverage information, please refer to the Summary of Benefits and Coverage (SBC) and consult the Plan Document for full terms and conditions.

Point of Service (POS)			High-Deductible Health Plan (HDHP)		
Plan Features	**Augusta Network (Tier 1) Member Cost Share**	**Aetna Network (Tier 2) Member Cost Share**	**Plan Features**	**Augusta Network (Tier 1) Member Cost Share**	**Aetna Network (Tier 2) Member Cost Share**
Deductible (amount paid before the plan begins to pay)	Single $700 Family $1,400	Single $2,000 Family $4,000	**Deductible (amount paid before the plan begins to pay)**	Single $2,000 Family $4,000	Single $3,000 Family $6,000
Maximum Out-of-Pocket (payment limit per year for covered services)	Single $4,000 Family $8,000	Single $7,000 Family $14,000	**Maximum Out-of-Pocket (payment limit per year for covered services)**	Single $5,000 Family $9,000	Single $8,500 Family $16,000
***Preventative Care**	Covered at 100%	Covered at 100%	***Preventative Care**	Covered at 100%	Covered at 100%
Out-of-Network Coverage	No	No	**Out-of-Network Coverage**	No	No
*Many preventive services are covered at 100% when using an in-network provider. If non-preventive services (e.g., lab work or diagnostic tests) are provided during the visit, copays or coinsurance may apply.					
Pre-tax Savings					
Spending Account Option(s)	Medical Health Care (FSA)		**Spending Account Option(s)**	Health Savings Account (HSA) and Limited Purpose Dental & Vision (FSA)	
Health Savings (HSA) Employer Contribution	N/A		**Health Savings (HSA) Employer Contribution**	January 1st Team Member Only: $1,000; January 1st Family: $2,000 (January 1 full amount, otherwise prorated)	
Physician's Services					
Primary Care Office Visit	$20 Copay, then 100% deductible waived	$45 Copay, then 100% deductible waived	**Primary Care Office Visit**	20% after deductible	35% after Tier 1 deductible
Specialist Office Visit	$55 Copay, then 100% deductible waived	$75 Copay, then 100% deductible waived	**Specialist Office Visit**	20% after deductible	40% after Tier 1 deductible
Primary Care Office Surgery	$20 Copay, then 100% deductible waived	40% after deductible	**Primary Care Office Surgery**	20% after deductible	35% after deductible
Specialist Office Surgery	$55 Copay, then 100% deductible waived	40% after deductible	**Specialist Office Surgery**	20% after deductible	40% after deductible
OB/GYN Primary Care Office Visit	$20 Copay, then 100% deductible waived	$45 Copay, then 100% deductible waived	**OB/GYN Primary Care Office Visit**	20% after deductible	35% after Tier 1 deductible
OB/GYN Specialist Office Visit	$55 Copay, then 100% deductible waived	$75 Copay, then 100% deductible waived	**OB/GYN Specialist Office Visit**	20% after deductible	40% after Tier 1 deductible

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Emergency Services					
Emergency Room Services	20% after deductible	20% after Tier 1 deductible	**Emergency Room Services**	20% after deductible	20% after Tier 1 deductible
***Urgent Care Clinic**	$75 Copay, then 100% deductible waived	$75 Copay, then 100% deductible waived	***Urgent Care Clinic**	20% after deductible	20% after Tier 1 deductible
Ambulance Services	20% after deductible	20% after Tier 1 deductible	**Ambulance Services**	20% after deductible	20% after Tier 1 deductible
*Copay applies to the Urgent Care physician office visit component only. If additional urgent care services (e.g., lab work or diagnostic tests) are provided during the visit, copays or coinsurance may apply.					
Maternity					
Delivery	20% after deductible	30% after deductible	**Delivery**	20% after deductible	30% after deductible
Birthing Center	20% after deductible	30% after deductible	**Birthing Center**	20% after deductible	30% after deductible
***Preventative Prenatal and Breastfeeding Support**	100% deductible waived	100% deductible waived	***Preventative Prenatal and Breastfeeding Support**	100% deductible waived	100% deductible waived
Lactation Consultations	100% deductible waived	100% deductible waived	**Lactation Consultations**	100% deductible waived	100% deductible waived
Routine Newborn Care	20% deductible waived	30% deductible waived	**Routine Newborn Care**	20% after deductible	30% after deductible
All other Prenatal and Postnatal Care	20% deductible waived	30% deductible waived	**All other Prenatal and Postnatal Care**	20% after deductible	30% after deductible
Note: Ultrasounds for a maternity diagnosis are unlimited. *Many preventive services are covered at 100% when using an in-network provider. If non-preventive services (e.g., lab work or diagnostic tests) are provided during the visit, copays or coinsurance may apply.					

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Mental Health					
Inpatient Mental Health	20% deductible waived	20% deductible waived	**Inpatient Mental Health**	20% after deductible	20% after Tier 1 deductible
Outpatient Mental Health Office Visit	$20 Copay, then 100% deductible waived	$20 Copay, then 100% deductible waived	**Outpatient Mental Health Office Visit**	20% after deductible	20% after Tier 1 deductible
All other Outpatient Mental Health Care	20% deductible waived	20% deductible waived	**All other Outpatient Mental Health Care**	20% after deductible	20% after Tier 1 deductible
Hospice Bereavement Counseling	20% deductible waived	20% deductible waived	**Hospice Bereavement Counseling**	20% after deductible	20% after Tier 1 deductible
Other Services					
Allergy Services Office Visit	$20 Copay, then 100% deductible waived	$20 Copay, then 100% deductible waived	**Allergy Services Office Visit**	20% after deductible	20% after Tier 1 deductible
All Other Allergy Services	20% after deductible	20% after Tier 1 deductible	**All Other Allergy Services**	20% after deductible	20% after Tier 1 deductible
Ambulatory Surgical Center	20% after deductible	40% after deductible	**Ambulatory Surgical Center**	20% after deductible	40% after deductible
Anesthetics	20% after deductible	40% after deductible	**Anesthetics**	20% after deductible	40% after deductible
Blood and Blood Derivatives	20% after deductible	40% after deductible	**Blood and Blood Derivatives**	20% after deductible	40% after deductible
Cardiac Rehab Outpatient	20% after deductible	40% after deductible	**Cardiac Rehab Outpatient**	20% after deductible	40% after deductible
Cardiac Rehab Outpatient Maximum 36 visit benefit per 12 week period or per occurrence.					

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Other Services (continued)					
Chemotherapy Outpatient	20% after deductible	40% after deductible	**Chemotherapy Outpatient**	20% after deductible	40% after deductible
Chiropractic Care / Spinal Manipulation	20% after deductible	20% after Tier 1 deductible	**Chiropractic Care / Spinal Manipulation**	20% after deductible	20% after Tier 1 deductible
Chiropractic Care / Spinal Manipulation Maximum 10 visits per calendar year.					
Dermatology Office Visit	$20 Copay, then 100% deductible waived	$20 Copay, then 100% deductible waived	**Dermatology Office Visit**	20% after deductible	20% after Tier 1 deductible
All Other Dermatology Services	20% after deductible	20% after Tier 1 deductible	**All Other Dermatology Services**	20% after deductible	20% after Tier 1 deductible
Diabetic Supplies	20% deductible waived	30% deductible waived	**Diabetic Supplies**	20% after deductible	30% after Tier 1 deductible
Diagnostic Testing Outpatient (X-Ray and Lab Services)	20% after deductible	40% after deductible	**Diagnostic Testing Outpatient (X-Ray and Lab Services)**	20% after deductible	40% after deductible
Dialysis Outpatient	20% after deductible	20% after Tier 1 deductible	**Dialysis Outpatient**	20% after deductible	20% after Tier 1 deductible
Durable Medical Equipment (DME)	20% after deductible	40% after deductible	**Durable Medical Equipment (DME)**	20% after deductible	40% after deductible
Hearing Aids	100% deductible waived	100% deductible waived	**Hearing Aids**	100% after deductible	100% after Tier 1 deductible
Hearing Aids Maximum Benefit is $2,000 every 48 months. Hearing Aids by a non-participating provider will be paid at the Tier 1 level of benefits.					
Home Health Care	20% after deductible	40% after deductible	**Home Health Care**	20% after deductible	40% after deductible
Home Health Care Calendar Year Maximum Benefit is 90 visits.					
Hospice Care	20% after deductible	40% after deductible	**Hospice Care**	20% after deductible	40% after deductible
Hospital Inpatient Expenses/ Hospital Facility Charges	20% after deductible	40% after deductible	**Hospital Inpatient Expenses/ Hospital Facility Charges**	20% after deductible	40% after deductible

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Plan Features	**Augusta Network (Tier 1) Member Cost Share**	**Aetna Network (Tier 2) Member Cost Share**	**Plan Features**	**Augusta Network (Tier 1) Member Cost Share**	**Aetna Network (Tier 2) Member Cost Share**
Other Services (continued)					
Infusion Therapy Outpatient	20% after deductible	40% after deductible	**Infusion Therapy Outpatient**	20% after deductible	40% after deductible
Long-Term Acute Care Facility	20% after deductible	40% after deductible	**Long-Term Acute Care Facility**	20% after deductible	40% after deductible
Medical and Surgical Supplies	20% after deductible	40% after deductible	**Medical and Surgical Supplies**	20% after deductible	40% after deductible
Morbid Obesity / Bariatric Surgery	25% after deductible	25% after Tier 1 Deductible	**Morbid Obesity / Bariatric Surgery**	25% after deductible	25% after Tier 1 Deductible
Morbid Obesity / Bariatric Surgery Lifetime Maximum Benefit: 1 Bariatric Surgical Procedure.					
Nutritional Counseling - first 30 visits per calendar yr.	100% deductible waived	100% deductible waived	**Nutritional Counseling - first 30 visits per calendar yr.**	100% after deductible	100% after Tier 1 deductible
Nutritional Counseling - additional visits	$20 Copay, then 100% deductible waived	$20 Copay, then 100% deductible waived	**Nutritional Counseling - additional visits**	20% after deductible	20% after Tier 1 deductible
Orthotics	20% after deductible	40% after deductible	**Orthotics**	20% after deductible	40% after deductible
Outpatient Hospital Services	20% after deductible	40% after deductible	**Outpatient Hospital Services**	20% after deductible	40% after deductible
Outpatient Therapies	20% after deductible	40% after deductible	**Outpatient Therapies**	20% after deductible	40% after deductible
Combined Calendar Year Maximum Benefit for Outpatient Therapies (physical, speech, hearing, occupational) maximum 30 visits per calendar year. Additional visits may be allowed based on Medical Necessity.					
Pain Management	20% after deductible	40% after deductible	**Pain Management**	20% after deductible	40% after deductible
Private Duty Nursing	20% after deductible	40% after deductible	**Private Duty Nursing**	20% after deductible	40% after deductible
Private Duty Nursing Calendar Year Maximum Benefit is 70 visits (up to 8 hour visits).					

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Other Services (continued)					
Prosthetics	20% after deductible	40% after deductible	**Prosthetics**	20% after deductible	40% after deductible
Radiation Therapy Outpatient	20% after deductible	40% after deductible	**Radiation Therapy Outpatient**	20% after deductible	40% after deductible
Respiratory / Pulmonary Therapy Outpatient	20% after deductible	40% after deductible	**Respiratory / Pulmonary Therapy Outpatient**	20% after deductible	40% after deductible
Respiratory / Pulmonary Therapy Calendar Year Maximum Benefit is 36 hours or a 6 week period.					
Retail Care Clinic	$20 Copay, then 100% deductible waived	$45 Copay, then 100% deductible waived	**Retail Care Clinic**	20% after deductible	35% after Tier 1 Deductible
Skilled Nursing Facility / Rehabilitation Facility	20% after deductible	40% after deductible	**Skilled Nursing Facility / Rehabilitation Facility**	20% after deductible	40% after deductible
Skilled Nursing Facility / Rehab Facility Calendar Year Maximum Benefit is 100 days.					
Smoking Cessation	$20 Copay, then 100% deductible waived	$20 Copay, then 100% deductible waived	**Smoking Cessation**	20% after deductible	20% after Tier 1 deductible
Smoking Cessation Calendar Year Maximum Benefit is 8 visits (60 minutes per visit).					
Surgery Facility and Professional Outpatient Fees	20% after deductible	40% after deductible	**Surgery Facility and Professional Outpatient Fees**	20% after deductible	40% after deductible
Telemedicine	$20 Copay, then 100% deductible waived	$20 Copay, then 100% deductible waived	**Telemedicine**	20% after deductible	20% after Tier 1 deductible
Temporomandibular Joint Dysfunction (TMJ)	20% after deductible	40% after deductible	**Temporomandibular Joint Dysfunction (TMJ)**	20% after deductible	40% after deductible
***Transplants**	Not Provided	25% after Tier 1 Deductible	***Transplants**	Not Provided	25% after Tier 1 Deductible
*Transplants: Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit. Cornea Transplants: When preformed by any in-network provider are covered under the Plan as a separate benefit and are paid at the same rate as any other illness.					
Wig (for Medical Necessity)	20% after deductible	40% after deductible	**Wig (for Medical Necessity)**	20% after deductible	40% after deductible
Wig for Medical Necessity - Lifetime Maximum Benefit is 1 wig					

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Prescription Drug					
Preventative Drug (as defined by HHS)	$0 Copay, deductible waived	$0 Copay, deductible waived	**Preventative Drug (as defined by HHS)**	100% deductible waived	100% deductible waived
Generic Drug: Retail Pharmacy 1-30 day supply	$20 Copay	$40 Copay	**Generic Drug: Retail Pharmacy 1-30 day supply**	30% after deductible	50% after deductible
Preferred Drug: Retail Pharmacy 1-30 day supply	$40 Copay	$75 Copay	**Preferred Drug: Retail Pharmacy 1-30 day supply**	30% after deductible	50% after deductible
Non-Preferred Drug: Retail Pharmacy 1-30 day supply	Greater of 40% up to $75	Greater of 50% up to $100	**Non-Preferred Drug: Retail Pharmacy 1-30 day supply**	30% after deductible	50% after deductible
Generic Drug: Retail Pharmacy 31-60 day supply	$27 Copay	$50 Copay	**Generic Drug: Retail Pharmacy 31-60 day supply**	30% after deductible	50% after deductible
Preferred Drug: Retail Pharmacy 31-60 day supply	$70 Copay	$115 Copay	**Preferred Drug: Retail Pharmacy 31-60 day supply**	30% after deductible	50% after deductible
Non-Preferred Drug: Retail Pharmacy 31-60 day supply	Greater of 40% up to $130	Greater of 50% up to $150	**Non-Preferred Drug: Retail Pharmacy 31-60 day supply**	30% after deductible	50% after deductible
Generic Drug: Retail Pharmacy 61-90 day supply	$34 Copay	$60 Copay	**Generic Drug: Retail Pharmacy 61-90 day supply**	30% after deductible	50% after deductible
Preferred Drug: Retail Pharmacy 61-90 day supply	$100 Copay	$155 Copay	**Preferred Drug: Retail Pharmacy 61-90 day supply**	30% after deductible	50% after deductible
Non-Preferred Drug: Retail Pharmacy 61-90 day supply	Greater of 40% up to $170	Greater of 50% up to $200	**Non-Preferred Drug: Retail Pharmacy 61-90 day supply**	30% after deductible	50% after deductible
Specialty Pharmacy Drug: 1-30 day supply	Not Provided	Greater of 50% up to $450	**Specialty Pharmacy Drug: 1-30 day supply**	Not Provided	50% after deductible

Specialty Pharmacy Drug(s) must be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for details.

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Prescription Drug (continued)					
Generic Drug: Mail Order Pharmacy 1-30 day supply	Not Provided	$40 Copay	**Generic Drug: Mail Order Pharmacy 1-30 day supply**	Not Provided	50% after deductible
Preferred Drug: Mail Order Pharmacy 1-30 day supply	Not Provided	$75 Copay	**Preferred Drug: Mail Order Pharmacy 1-30 day supply**	Not Provided	50% after deductible
Non-Preferred Drug: Mail Order Pharmacy 1-30 day supply	Not Provided	Greater of 50% up to $100	**Non-Preferred Drug: Mail Order Pharmacy 1-30 day supply**	Not Provided	50% after deductible
Generic Drug: Mail Order Pharmacy 31-60 day supply	Not Provided	$50 Copay	**Generic Drug: Mail Order Pharmacy 31-60 day supply**	Not Provided	50% after deductible
Preferred Drug: Mail Order Pharmacy 31-60 day supply	Not Provided	$115 Copay	**Preferred Drug: Mail Order Pharmacy 31-60 day supply**	Not Provided	50% after deductible
Non-Preferred Drug: Mail Order Pharmacy 31-60 day supply	Not Provided	Greater of 50% up to $150	**Non-Preferred Drug: Mail Order Pharmacy 31-60 day supply**	Not Provided	50% after deductible
Generic Drug: Mail Order Pharmacy 61-90 day supply	Not Provided	$60 Copay	**Generic Drug: Mail Order Pharmacy 61-90 day supply**	Not Provided	50% after deductible
Preferred Drug: Mail Order Pharmacy 61-90 day supply	Not Provided	$155 Copay	**Preferred Drug: Mail Order Pharmacy 61-90 day supply**	Not Provided	50% after deductible
Non-Preferred Drug: Mail Order Pharmacy 61-90 day supply	Not Provided	Greater of 50% up to $200	**Non-Preferred Drug: Mail Order Pharmacy 61-90 day supply**	Not Provided	50% after deductible