2027 Augusta Health Medical Benefit Options Side-by-Side

This document provides a high-level overview. For a complete list of services and 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**	**Cigna Network (Tier 2) Member Cost Share**	**Plan Features**	**Augusta Network (Tier 1) Member Cost Share**	**Cigna Network (Tier 2) Member Cost Share**
Deductible (amount paid before the plan begins to pay)	Single $700 Family $1,400	Single $3,000 Family $5,000	Deductible (amount paid before the plan begins to pay)	Single $2,000 Family $4,000	Single $4,000 Family $7,000
Maximum Out-of-Pocket (payment limit per year for covered services)	Single $4,000 Family $8,000	Single $8,000 Family $15,000	Maximum Out-of-Pocket (payment limit per year for covered services)	Single $5,000 Family $9,000	Single $8,700 Family $17,400
Out-of-Network Coverage	No	No	Out-of-Network Coverage	No	No
Preventative Care	Covered at 100%	Covered at 100%	Preventative Care	Covered at 100%	Covered at 100%
Many preventive services are covered at 100% when received from an in-network provider. Copays or coinsurance may apply to non-preventive services, such as lab work or diagnostic tests, provided during the same visit.					
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 Services (Including Primary Care, Dermatology, OB/GYN, and Other Specialties)					
Physician Office Visit (PCP & Non-Specialist)	$20 Copay	$55 Copay	Physician Office Visit (PCP & Non-Specialist)	20% after deductible	40% after deductible
Physician Office Visit Surgery	$20 Copay	40% after deductible	Physician Office Visit Surgery	20% after deductible	40% after deductible
Specialist Office Visit	$55 Copay	$95 Copay	Specialist Office Visit	20% after deductible	45% after deductible
Specialist Office Visit Surgery	$55 Copay	40% after deductible	Specialist Office Visit Surgery	20% after deductible	45% after deductible

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Emergency & Urgent Care Services					
Ambulance Services	20% after deductible	20% after Tier 1 deductible	Ambulance 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
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	$95 Copay	Urgent Care Clinic	20% after deductible	45% after deductible
The copay applies to the urgent care physician office visit only. Additional services, such as lab work or diagnostic tests, may be subject to separate copays or coinsurance.					
Maternity					
Delivery	20% after deductible	40% after deductible	Delivery	20% after deductible	40% after deductible
Lactation Consultations - up to 6 visits per year	$0 Copay	$0 Copay	Lactation Consultations - up to 6 visits per year	100% deductible waived	100% deductible waived
Routine Newborn Care	20% deductible waived	40% deductible waived	Routine Newborn Care	20% after deductible	40% after deductible
Note: Ultrasounds for a maternity diagnosis are unlimited. Many preventive services are covered at 100% when using an in-network provider. If additional non-preventive services are provided during the visit, copays or coinsurance may apply.					
Other Services					
Allergy Treatment	$20 Copay	$55 Copay	Allergy Treatment	20% after deductible	20% after Tier 1 deductible
Allergy Testing	20% after deductible	40% after Tier 1 deductible	Allergy Testing	20% after deductible	40% after Tier 1 deductible
Anesthesia Services	20% after deductible	40% after deductible	Anesthesia Services	20% after deductible	40% after deductible

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Other Services (continued)					
Bariatric Surgery	25% after deductible	40% after deductible	Bariatric Surgery	25% after deductible	40% after deductible
Maximum of one bariatric surgery procedure per lifetime; cosmetic procedures are not covered.					
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.					
Chemotherapy Outpatient	20% after deductible	40% after deductible	Chemotherapy Outpatient	20% after deductible	40% after deductible
Chiropractic Care / Spinal Manipulation	Not Provided	20% after Tier 1 deductible	Chiropractic Care / Spinal Manipulation	Not Provided	20% after Tier 1 deductible
Chiropractic Care / Spinal Manipulation Maximum 10 visits per calendar year.					
Cochlear Implants	20% after deductible	40% after deductible	Cochlear Implants	20% after deductible	40% after deductible
Dental Services	20% after deductible	40% after deductible	Dental Services	20% after deductible	40% after deductible
Dental coverage includes removal of soft-tissue impacted wisdom teeth; routine dental care is not covered.					
Diabetic Education	20% after deductible	40% after deductible	Diabetic Education	20% after deductible	40% after deductible
Diabetic Supplies (Disposable)	20% deductible waived	40% after deductible	Diabetic Supplies (Disposable)	20% after deductible	40% after deductible
Diabetic Equipment (DME, non-disposable)	20% deductible waived	30% after deductible	Diabetic Equipment (DME, non-disposable)	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

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Other Services (continued)					
Durable Medical Equipment (DME)	20% after deductible	40% after deductible	Durable Medical Equipment (DME)	20% after deductible	40% after deductible
Hearing Aids	$0 Copay	$0 Copay	Hearing Aids	$0 after deductible	$0 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
Hospice Counseling - Bereavement	20% deductible waived	20% deductible waived	Hospice Counseling - Bereavement	20% after deductible	20% after Tier 1 deductible
Hospital Observation	20% after deductible	40% after deductible	Hospital Observation	20% after deductible	40% after deductible
Infusion Therapy	20% after deductible	40% after deductible	Infusion Therapy	20% after deductible	40% after deductible
Inpatient - Facility and Professional (excludes mental health/sub abuse)	20% after deductible	40% after deductible	Inpatient - Facility and Professional (excludes mental health/sub abuse)	20% after deductible	40% after deductible
Inpatient - Mental Health & Substance Abuse	20% deductible waived	20% deductible waived	Inpatient - Mental Health & Substance Abuse	20% after deductible	20% after Tier 1 deductible
Laboratory Procedures	20% after deductible	40% after deductible	Laboratory Procedures	20% after deductible	40% after deductible
Lenses/Glasses Following Cataract Surgery	20% after deductible	40% after deductible	Lenses/Glasses Following Cataract Surgery	20% after deductible	40% after deductible
Limit: One initial pair of eyeglasses, contact lenses, or intraocular lens following a medically necessary cataract surgical procedure.					

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Other Services (continued)					
Medical Drugs	20% after deductible	40% after deductible	Medical Drugs	20% after deductible	40% after deductible
Medical Supplies	20% after deductible	40% after deductible	Medical Supplies	20% after deductible	40% after deductible
Morbid Obesity	25% after deductible	40% after deductible	Morbid Obesity	25% after deductible	40% after deductible
Nutritional Counseling Visits 1-30	$0 Copay	$0 Copay	Nutritional Counseling Visits 1-30	$0 Copay after deductible	$0 Copay after Tier 1 deductible
Nutritional Counseling Visits 31 or more	$20 Copay	$20 Copay	Nutritional Counseling Visits 31 or more	20% after deductible	20% after Tier 1 deductible
Orthotics	20% after deductible	40% after deductible	Orthotics	20% after deductible	40% after deductible
Outpatient Therapy (Occupational, Physical, & Speech)	20% after deductible	40% after deductible	Outpatient Therapy (Occupational, Physical, & Speech)	20% after deductible	40% after deductible
Maximum of 30 visits per calendar year; additional visits allowed when medically necessary.					
Prosthetic Devices	20% after deductible	40% after deductible	Prosthetic Devices	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 maximum of 70 visits per calendar year, with up to 8 hours per visit.					
Pulmonary Therapy - Outpatient	20% after deductible	40% after deductible	Pulmonary Therapy - Outpatient	20% after deductible	40% after deductible
Outpatient Pulmonary Therapy: Maximum of 20 visits per calendar year.					
Retail Care Clinic	$20 Copay	$55 Copay	Retail Care Clinic	20% after deductible	40% after Tier 1 deductible
Routine Eye Exam	$0 Copay	$0 Copay	Routine Eye Exam	$0 deductible waived	$0 deductible waived
Routine Eye Exam: Maximum of 1 visit per calendar year.					

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Other Services (continued)					
Routine Hearing Exam	$0 Copay	$0 Copay	Routine Hearing Exam	$0 deductible waived	$0 deductible waived
Routine Hearing Exam: Maximum of 1 visit per calendar year.					
Skilled Nursing	20% after deductible	40% after deductible	Skilled Nursing	20% after deductible	40% after deductible
Skilled Nursing maximum of 100 days per calendar year.					
Smoking Cessation	$20 Copay	$20 Copay	Smoking Cessation	20% after deductible	20% after Tier 1 deductible
Smoking Cessation: Maximum of 8 visits per calendar year, up to 60 minutes per visit.					
Surgery	20% after deductible	40% after deductible	Surgery	20% after deductible	40% after deductible
Telemedicine	$20 Copay	$20 Copay	Telemedicine	20% after deductible	20% after Tier 1 deductible
Therapeutic Radiology Services	20% after deductible	40% after deductible	Therapeutic Radiology Services	20% after deductible	40% after deductible
Transplant - Corneal	25% after deductible	25% after Tier 1 deductible	Transplant - Corneal	25% after deductible	25% after Tier 1 deductible
Corneal Transplants: Covered under surgical benefits through the Cigna LifeSOURCE Transplant Network.					
Transplants	Not Provided	25% after Tier 1 deductible	Transplants	Not Provided	25% after Tier 1 deductible
Transplants: Covered under surgical benefits through the Cigna LifeSOURCE Transplant Network. Transplant Travel & Lodging: Covered when authorized. Lodging limited to $50 per person or $100 per night. Maximum combined travel and lodging benefit of $10,000 per transplant.					
Wig for medical necessity	20% after deductible	40% after deductible	Wig for medical necessity	20% after deductible	40% after deductible
Wigs (When Medically Necessary): Maximum benefit of $200 per calendar year.					

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Prescription Drug					
Preventative Drug (as defined by HHS)	$0 Copay	$0 Copay	Preventative Drug (as defined by HHS)	100% deductible waived	100% deductible waived
Generic Drug: Retail Pharmacy 1-30 day supply	$20 Copay	$45 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	$85 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 $110	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	$55 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	$125 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 $160	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	$65 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	$165 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 $210	Non-Preferred Drug: Retail Pharmacy 61-90 day supply	30% after deductible	50% after deductible
Specialty Pharmacy Drug: 1-30 day supply	Greater of 50% up to $450	Greater of 50% up to $450	Specialty Pharmacy Drug: 1-30 day supply	30% after deductible	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					
Generic Drug: Mail Order Pharmacy 1-30 day supply	Not Provided	$45 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	$85 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 $110	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	$55 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	$125 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 $160	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	$65 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	$165 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 $210	Non-Preferred Drug: Mail Order Pharmacy 61-90 day supply	Not Provided	50% after deductible