



BENEFITS AT A GLANCE

2026 Benefit Highlights for Non Union Associates at Brownwood & Huntsville

MEDICAL PLAN OPTIONS

Eligible: 1st day of employment

PPO

(Preferred Provider Organization)

HDHP

(High Deductible Health Plan)

LIFETIME MAXIMUM BENEFIT	None		None	
ANNUAL DEDUCTIBLE	\$1,500 Individual \$3,000 Family		\$3,400 Individual \$6,800 Family	
COPAYS & COINSURANCE	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹
COPAYS ²	Primary Care: \$25 Specialty Visit: \$100 Urgent Care: \$75 Emergency Room: \$350	Not Applicable	Not Applicable	Not Applicable
VIRTUAL VISITS	\$10	Not Applicable	\$10 after deductible	Not Applicable
PREVENTIVE CARE	100% no deductible	70% of R&C after deductible	100% no deductible	60% of R&C after deductible
COINSURANCE ³	85% after deductible	70% of R&C after deductible	80% after deductible	60% of R&C after deductible
COINSURANCE LIMIT Excludes deductibles; under PPO Plan also excludes copays and prescription drug coinsurance.	\$2,300 Individual \$4,600 Family	\$4,600 Individual \$9,200 Family	\$1,000 Individual \$2,000 Family	\$2,000 Individual \$4,000 Family
OUT OF POCKET MAXIMUM Includes deductibles, medical and prescription drug coinsurance and copays. Once met plan pays 100%.	\$7,500 Individual \$15,000 Family	Not Applicable	\$4,400 Individual \$8,800 Family	Not Applicable
PRESCRIPTION DRUGS	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS Must use generic drugs Maintenance drugs must be filled as 90-day supply through mail order or Walgreens. Minimum copay doubles for 90-day prescriptions.	No deductible Plan pays: • 90% generic (\$15 minimum copay) • 70% preferred brand (\$30 minimum copay) • 50% non-preferred brand (\$60 minimum copay) \$300 maximum cost for mail order or Walgreens	No Coverage	After deductible Plan pays: • 90% generic (\$15 minimum copay) • 70% preferred brand (\$30 minimum copay) • 50% non-preferred brand (\$60 minimum copay) \$300 maximum cost for mail order or Walgreens (after deductible)	No Coverage
COVERAGE & ENROLLMENT				
SPOUSAL/DOMESTIC PARTNER SURCHARGE	\$150/month If enroll working spouse/domestic partner with medical coverage available through employer			
CHILD COVERAGE	Covered up to age 26			
DEFAULT IF YOU DO NOT ENROLL OR WAIVE	New Hire / Newly Eligible: Waive (No coverage) Annual Open Enrollment: Your election will continue for next year (unless otherwise communicated)			

¹Out-of-Network: Out-of-network benefits are limited to the reasonable and customary (R&C) charge as determined by the medical plan administrator. You are responsible for any amounts in excess of R&C if you use an out-of-network provider.

²PPO Copays: The \$25 primary care copay includes OB/GYN and behavioral health. The \$100 specialty visit copay includes, but is not limited to, chiropractic services (up to 25 visits/year), occupational/physical therapy (up to 60 visits/year).

³PPO Coinsurance: Inpatient visits; surgery; x-rays and lab tests; ambulance; emergency room services; hospital (inpatient/outpatient); maternity care; allergy testing/treatment; home health care (up to 120 visits/year); durable medical equipment; mental health/substance abuse treatment.