



# BENEFITS AT A GLANCE

2025 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	\$1,200 Individual   \$2,400 Family		\$3,300 Individual   \$6,600 Family	
<b>COPAYS &amp; COINSURANCE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK<sup>1</sup></b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK<sup>1</sup></b>
COPAYS <sup>2</sup>	Primary Care: \$25 Specialty Visit: \$75 Urgent Care: \$75 Emergency Room: \$250	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 <sup>3</sup>	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	\$4,300 Individual \$8,600 Family	Not Applicable
<b>PRESCRIPTION DRUGS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
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
<b>COVERAGE &amp; ENROLLMENT</b>				
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)			

<sup>1</sup>Out-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.

<sup>2</sup>PPO Copays: The \$25 primary care copay includes OB/GYN and behavioral health. The \$75 specialty visit copay includes, but is not limited to, chiropractic services (up to 25 visits/year), occupational/physical therapy (up to 60 visits/year).

<sup>3</sup>PPO 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.