

Washington County
Effective Date: January 1, 2026

Washington County Medical Plan Options						
Benefits	Plan 1 (D)		Plan 2 H.S.A. (C)		Plan 3 - H.S.A. (E)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Individual	\$750		\$2,000		\$3,000	
Family	\$1,500		\$4,000		\$6,000	
Coinsurance	90/10%	80/20%	100/0%	80/20%	100/0%	80/20%
Out of Pocket Maximum						
Individual	\$1,500		\$2,000	\$3,000	\$3,000	\$4,000
Family	\$3,000		\$4,000	\$5,000	\$6,000	\$8,000
Hospitalization	ded/coins	ded/coins	deductible then 100%	ded/coins	deductible then 100%	ded/coins
Emergency Room (copay waived if admitted to the hospital)	\$100 Copay, then deductible and coinsurance	\$100 Copay, then deductible and coinsurance	deductible then 100%	ded/coins	deductible then 100%	ded/coins
Office Visit	\$20 copay	ded/coins	deductible then 100%	ded/coins	deductible then 100%	ded/coins
Wellness Benefit	100% benefit	ded/coins	100% benefit	ded/coins	100% benefit	ded/coins
Prescription Drugs	Tier 1 - \$5 (Generic / Pref brand) Tier 2 - \$30 (Non pref Brand / Biosimilar) Tier 3 - \$50 (Preferred Specialty) Tier 4- \$100 (Non-Preferred Specialty)		deductible then 100%		deductible then 100%	
Monthly Total Premium						
Single	\$905		\$760		\$680	
Family	\$2,130		\$1,566		\$1,420	
Monthly County Contribution						
Single	\$905		\$905		\$905	
Family	\$1,566		\$1,566		\$1,566	
Employee Contributions (Cost Per Month)	Plan 1 (D)		Plan 2 (HSA) (C)		PLAN 3 (HSA) (E)	
Health Risk Assessment (HRA)	Without HRA	With HRA	Without HRA	With HRA	Without HRA	With HRA
Single	\$25	\$0	-\$120	-\$145	-\$200	-\$225
*Family	\$614	\$564	\$50	\$0	-\$96	-\$146

This outline summarizes certain provisions of the plans illustrated. Complete plan information is included in the Washington County Group Health Plan Document.

**Figures shown reflect those electing full family coverage with 2 adults on the plan reflecting a \$25 HRA incentive per adult. Those enrolling as in family coverage though only 1 adult on the plan will have premiums reflected accordingly.*

Medical Plan Elected	(Circle the plan elected)	Plan 1 (D)	Plan 2 (C)	Plan 3 (E)	Contributions - HSA Only
Type of Coverage Elected	(Circle the coverage elected)	Single	Family		Same as 2025
DECLINE COVERAGE	Reason for Decline : _____				Other Amount: _____ x 26 = _____ (annual)

Employee Name
(Please print)

Employee Signature

Date
