Washington County
Effective Date: January 1, 2022

	Washington County Medical Plan Options					
Benefits	**Plan 1**		**Plan 2**		**Plan 3 - H.S.A**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible						
Individual	$500		$1,000		$2,000	
Family	$1,000		$2,000		$4,000	
Coinsurance	90/10%	80/20%	90/10%	80/20%	100/0%	80/20%
Out of Pocket Maximum						
Individual	$1,000		$2,000		$2,000	$3,000
Family	$2,000		$4,000		$4,000	$5,000
Hospitalization	ded/coins	ded/coins	ded/coins	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	$100 Copay, then deductible and coinsurance	$100 Copay, then deductible and coinsurance	deductible then 100%	ded/coins
Office Visit	$20 copay	ded/coins	$20 copay	ded/coins	deductible then 100%	ded/coins
Wellness Benefit	100% benefit	ded/coins	100% benefit	ded/coins	100% benefit	ded/coins
Prescription Drugs	$4 Generic $25 Brand Name $40 Non-Preferred Brand Name		$4 Generic $25 Brand Name $40 Non-Preferred Brand Name		deductible then 100%	
Monthly Total Premium						
Single	$753		$685		$626	
Family	$1,769		$1,570		$1,300	
Monthly County Contribution						
Single	$753		$753		$753	
Family	$1,300		$1,300		$1,300	
Employee Contributions (Cost Per Month)	**Plan 1**		**Plan 2**		**PLAN 3 (HSA)**	
Health Risk Assessment (HRA)	**Without HRA**	**With HRA**	**Without HRA**	**With HRA**	**Without HRA**	**With HRA**
Single	$25	$0	-$43	-$68	-$102	-$127
Family	$519	$469	$320	$270	$50	$0

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

Medical Plan Elected (Circle the plan elected) 1 2 3 Contributions - **HSA Only**

Type of Coverage Elected (Circle the coverage elected) Single Family Same as 2021

DECLINE COVERAGE Reason for Decline : _____ Other Amount: _____ x 26 = _____ (annual)

Employee Name (Please print) _____

Employee Signature _____ **Date** _____