



WCA GROUP HEALTH TRUST

		2026		
		Health Benefit Plan		
		UHC Choice Plus Network		
Deductible	In Network	Single \$2,000	Employee +1 \$2,750 (\$1,375 Ind)	Family \$3,500 (\$2,000 Ind)
	Out of Network	\$2,000	\$2,750 (\$1,375 Ind)	\$3,500 (\$2,000 Ind)
Coinsurance	In Network	90%		
	Out of Network	70%		
Maximum Out of Pocket	In Network	Single \$4,000	Employee +1 \$5,250 (\$2,625 Ind)	Family \$6,500 (\$4,000 Ind)
	Out of Network	\$4,500	\$6,000 (\$3,000 Ind)	\$7,500 (\$4,500 Ind)
Medical Benefits		In Network	Out of Network	
		Copay / Deductible / Co-insurance	Copay / Deductible / Co-insurance	
	Inpatient Hospitalization	Deductible / 90%	Deductible / 70%	
	Outpatient Hospitalization	Deductible / 90%	Deductible / 70%	
	Office Visit(s)	\$25 / Deductible / 90%	\$50 / Deductible / 70%	
	Specialist Office Visit(s)	\$25 / Deductible / 90%	\$50 / Deductible / 70%	
	Preventative Care	100% - Deductible Waived	\$50 / Deductible / 70%	
	Annual Vision Exam	100% Deductible Waived		
	Chiropractic Office Visits(s) <i>(Limited to 12 visits per Benefit Year)</i>	\$25 / Deductible / 90%	\$50 / Deductible / 70%	
	Physical, Occupational, Speech and Respiratory Therapy	\$25 / Deductible / 90%	\$50 / Deductible / 70%	
	Urgent Care	\$25 / Deductible / 90%	\$50 / Deductible / 70%	
	Emergency Room Care	\$200 / Deductible / 90%		
	All Other Medical Services	Deductible / 90%	Deductible / 70%	
	MRI / CT Scan / Pet Scan	Deductible / 90%	Deductible / 70%	
	Mental Health / Substance Abuse			
	Office Visit	\$25 / Deductible / 90%	\$50 / Deductible / 70%	
	Inpatient	Deductible / 90%	Deductible / 70%	
	Outpatient	Deductible / 90%	Deductible / 70%	
	Smoking Cessation Benefit	100% Deductible Waived, no Lifetime Maximum		
	Teladoc Benefit	100% (Including Behavioral Health and Dermatology Coverage)		
EMPLOYEE HEALTH & WELLNESS CENTER		No Copay, No Deductible and No Co-insurance		
Astia Health 1000 Lake View Drive, Suite 200 Wausau, WI 54403 (Enter Door 34)		Convenient Personalized Care at No Cost to Marathon County Employees and their Dependents enrolled in the WCA-Group Health Trust Plan		
Clinic Hours		Schedule an Appointment: 715-448-8575		
Monday: 8:00 am – 4:00 pm		Other Locations: Weston / Abbotsford / Marshfield		
Tuesday: 7:00 am – 5:00 pm				
Wednesday: 9:00 am – 5:00 pm				
Thursday: 7:00 am – 5:00 pm				
Friday: 8:00 am – 4:00 pm				

**2026
Health Benefit Plan**

National Rx / CVS Caremark

Pharmacy – Drug Plan

	Generic	Preferred Brand	Non-Preferred Brand
Value Priced	\$0		
Retail Pharmacy 30 Day Supply	\$5	\$20	\$40
Retail Pharmacy 31-90 Day Supply	\$15	\$60	\$120
Mail Order 90 Day Supply	\$5	\$40	\$80
Specialty Mail – 30 Day Supply*	\$5	\$20	\$40

Rx copays are not applied to the health plan deductible but are applied to the health plan maximum out of pocket.

Mail Order: Online at Caremark.com/mailexpress or by phone 866-818-6911

*Specialty Drugs: Administration of these injectable (Specialty) drugs in a physician's office or other outpatient facility is limited to one office visit and two home care visits for drug administration and/or training per prescription. After the limit is met, the Specialty drugs must be purchased through the **Specialty Pharmacy Program**.

Vision Hardware Benefit

(Limited to Either Eyeglasses or Contact Lenses per Benefit Year)

Eyeglass Lenses

(Limited to 1 Pair Single Vision, Bifocal, No-Line Bifocal or Trifocal Lenses per Benefit Year)

Pediatric Services - Up to 19 years of age

(Frames and Contact Lenses: Limited to 1 set per Benefit Year. Disposable Contact Lenses Limited to 1-year Supply per Benefit Year)

Non-Pediatric Services - Ages 19 and Older

(Frames and Contact Lenses: Limited to \$100 per Benefit Year)

**In Network
Copay / Deductible / Co-insurance**

100% - Deductible Waived

100% - Deductible Waived

100% - Deductible Waived
(\$100 Limit)

**Out of Network
Copay / Deductible / Co-insurance**

100% - Deductible Waived

100% - Deductible Waived

100% - Deductible Waived
(\$100 Limit)

Employee

Monthly Premiums

(Full-Time Employees)

	<u>No Incentive</u>	<u>With Incentive</u>
Single =	\$145.11	\$ 96.74
Employee +1 =	\$348.25	\$232.17
Family =	\$409.21	\$272.81

Health

**Reimbursement
Arrangement (HRA)**

Single	\$750 annual	\$3,750 maximum
Employee + 1	\$1,125 annual	\$5,625 maximum
Family	\$1,500 annual	\$7,500 maximum

Reimbursement for **covered** out-of-pocket medical expenses only
(deductible, co-insurance, co-pay or prescription drugs)

The HRA does not automatically reimburse copays or prescription drug expenses