



WCA GROUP HEALTH TRUST

		2025 Health Benefit Plan		
		UHC Choice Plus Network		
Deductible		Single	Employee +1	Family
	In Network	\$2,000	\$2,750 (\$1,375 Ind)	\$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		Single	Employee +1	Family
	In Network	\$4,000	\$5,250 (\$2,625 Ind)	\$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 <i>(Prior authorization required for all therapy)</i>	\$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 1000 Lake View Drive, Suite 200 Wausau, WI 54403 (Enter Door 34)		No Copay, No Deductible and No Co-insurance		
Clinic Hours Monday: 8:00 am – 4:00 pm 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		Convenient Personalized Care at No Cost to Marathon County Employees and their Dependents enrolled in the WCA-Group Health Trust Plan		
		Schedule an Appointment: 715-448-8575 Other Locations: Weston / Abbotsford / Marshfield		

**2025
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

	<u>No Incentive</u>	<u>With Incentive</u>
Single =	\$136.23	\$ 90.83
Employee +1 =	\$327.00	\$217.99
Family =	\$384.23	\$256.15

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