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WCA GROUP HEALTH TRUST

	2024 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*** *Copay / Deductible / Co-insurance*	***Out of Network*** *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) *(Limited to 12 visits per Benefit Year)*	$25 / Deductible / 90%	$50 / Deductible / 70%
Physical, Occupational, Speech and Respiratory Therapy *(Prior authorization required for all 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 Inpatient Outpatient	 $25 / Deductible / 90% Deductible / 90% Deductible / 90%	 $50 / Deductible / 70% Deductible / 70% Deductible / 70%
Smoking Cessation Benefit	100% Deductible Waived, no Lifetime Maximum	
Teladoc Benefit	100% (Including Behavioral Health and Dermatology Coverage)	

EMPLOYEE HEALTH & WELLNESS CENTER
1100 Lakeview Drive, Wausau, WI
North Central Health Care Campus

Clinic Hours
Monday - Wednesday - Friday:
8:00 am - 4:30 pm
Tuesday: 6:30 am – 3:00 pm
Thursday: 9:30 am – 6:00 pm

No Copay, No Deductible and No Co-insurance

Convenient Personalized Care at No Cost to Marathon County Employees and their Dependents enrolled in the WCA-Group Health Trust Plan

Schedule an Appointment: 715.843.1256 or MyAspirus.org

2024
Health Benefit Plan

Pharmacy – Drug Plan

National Rx / CVS Caremark

	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/mailservice 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)

	In Network *Copay / Deductible / Co-insurance*	*Out of Network* *Copay / Deductible / Co-insurance*
Eyeglass Lenses *(Limited to 1 Pair Single Vision, Bifocal, No-Line Bifocal or Trifocal Lenses per Benefit Year)*	100% - Deductible Waived	100% - Deductible Waived
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)*	100% - Deductible Waived	100% - Deductible Waived
Non-Pediatric Services - Ages 19 and Older *(Frames and Contact Lenses: Limited to $100 per Benefit Year*	100% - Deductible Waived *($100 Limit)*	100% - Deductible Waived *($100 Limit)*

Employee Monthly Premiums

	No Incentive	With Incentive
Single =	$127.92	$ 85.28
Employee +1 =	$307.04	$204.69
Family =	$360.78	$240.52

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