2021

SPOKANE TRANSIT AUTHORITY	MEDICAL BENEFITS EFFECTIVE JANUARY 1, 2021			1598, 3939 & Non-Reps Only
Carrier/Administrator	**Premera Blue Cross**	**Kaiser Permanente**	**Kaiser Permanente**	**Kaiser Permanente**
Plan Description	Heritage Plus 1	Kaiser Permanente Buy Up	Kaiser Permanente Core	Kaiser Permanente CDHP
Provider Network	Heritage Plus Network	Kaiser Core Network	Kaiser Core Network	Kaiser Access PPO
In-Network Providers	**In-Network**	**In-Network**	**In-Network**	**In-Network**
General Plan Information				
Annual Deductible (Ind/Fam)	$250/$750	$250/$500	$350/$700	$1,400/$2,800*
Annual Out-of-Pocket Maximum (Ind/Fam)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000	$4,200/$6,850* *If enrolled as a family, the family amount must be met
Coinsurance (*after deductible met*)	85/15	No Plan Coinsurance	No Plan Coinsurance	85/15
Professional Services		***Primary Care*** / ***Specialist***	***Primary Care*** / ***Specialist***	
Office Visit - *Exams/Consultations*	15% after ded	$15 Copay / $30 Copay, after deductible	$20 Copay / $40 Copay, after deductible	15% after ded (5% when outpatient services provided by enhanced provider)
Diagnostic X-Ray & Lab - *Simple*	15% after ded	Subject to deductible then 100%	Subject to deductible then 100%	15% after ded
Major Imaging - *MRI, CT, PET*	15% after ded	$30 Copay after deductible	$40 Copay after deductible	15% after ded
Preventive Care	Covered in full	Covered in full	Covered in full	Covered in full
Hospital Services				
Inpatient Hospital	$200/day (up to $600/yr) + ded + coins	$150/day, $750/admission after ded	$200/day, $1,000/admission after ded	15% after ded
Outpatient Hospital	15% after ded	$150 Copay after deductible	$200 Copay after deductible	15% after ded
Emergency Services				
Emergency Room	$75 Copay after ded + coins	$250 Copay after deductible	$300 Copay after deductible	15% after ded
Urgent Care	15% after ded	$15 Copay	$20 Copay	15% after ded
Ambulance	15% after ded	20% (ded waived)	20% (ded waived)	15% after ded
Other Services				
Mental Health Benefits:				
Inpatient Care	$200/day (up to $600/yr) + ded + coins	$150/day, $750/admission after ded	$200/day, $1,000/admission after ded	15% after ded
Outpatient Care	15% after ded	$15 Copay	$20 Copay	15% after ded
Chiropractic	15% after ded	$15 Copay (up to 10 visits per year)	$20 Copay (up to 10 visits per year)	15% after ded (up to 15 visits per year)
DME, Supplies & Prosthetics	15% (ded waived)	20% (ded waived)	20% (ded waived)	15% after ded
Outpatient Rehab Professional:	15% after ded (60 combined visits per year)	$15 Copay / $30 Copay, after deductible (60 combined visits per year)	$20 Copay / $40 Copay, after deductible (60 combined visits per year)	15% after ded (60 combined visits per year)
Hearing Exam	Covered in full (1 PCY)	$15 Copay after deductible	$20 Copay after deductible	15% after ded
Hearing Hardware	up to $800 every 36 months	up to $800 every 36 months	up to $800 every 36 months	up to $800 every 36 months
Routine Vision Care (1 visit PCY)	Covered in full	$15 Copay (ded waived)	$20 Copay (ded waived)	Covered in full
Optical Hardware (Adult age 19+)	up to $150 per 24 months	up to $150 per 24 months	up to $150 per 24 months	up to $150 per 24 months
Prescription Drugs	***$100 Deductible (does not apply to Generic)***	***Deductible waived***	***Deductible waived***	***Medical deductible applies***
Retail (30 days)	10%/30%/50%	$5/$20/$40/50% up to $250	$5/$20/$40/50% up to $250	15% after ded (5% after ded enhanced)
Mail Order (up to 90 days)	$10/$50/$100	$10/$40/$80/50% up to $750	$10/$40/$80/50% up to $750	2x enhanced cost share
Out-of-Network Providers	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Calendar Year Deductible (Ind/Fam)	Shared with In Network	Not applicable	Not applicable	Shared with In-network
Calendar Year Out-of-Pocket Maximum	Not Applicable	Not applicable	Not applicable	Shared with In-network
Coinsurance	60/40	Not covered	Not covered	60/40
Prescription Drugs	Cost Share then 40% to allowable	Not covered	Not covered	Not covered