SPOKANE TRANSIT AUTHORITY

MEDICAL BENEFITS

Effective January 1, 2024

1598, 3939 & Non-Reps Only

Carrier	**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 HMO Network	Kaiser Core HMO 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	**$1,600/$3,200**
Annual Out-of-Pocket Maximum (Ind/Fam)	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000	$4,200/$6,850
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, after deductible / $30 Copay, after deductible	$20 Copay, afer deductible / $40 Copay, after deductible	15% after ded
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, up to $750/admission after ded	$200/day, up to $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 after deductible	$20 Copay after deductible	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, up to $750/admission after ded	$200/day, up to $1,000/admission after ded	15% after ded
Outpatient Care	15% after ded	$15 Copay after deductible	$20 Copay after deductible	15% after ded
Chiropractic	15% after ded (up to 10 visits per year)	$15 Copay after deductible (up to 10 visits per year)	$20 Copay after deductible (up to 10 visits per year)	15% after ded (up to 15 visits per year)
Outpatient Rehab Professional:	15% after ded (60 combined visits per year)	$15 Copay, after deductible / $30 Copay, after deductible (60 combined visits per year)	$20 Copay, after deductible / $40 Copay, after deductible (60 combined visits per year)	15% after ded (60 combined visits per year)
Hearing Exam & Hardware	Exam and hardware covered up to $3,000 per ear per 36 months	Exam and hardware covered up to $3,000 per ear per 36 months	Exam and hardware covered up to $3,000 per ear per 36 months	Deductible then covered in full up to $3,000 per ear per 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 $200 per calendar year**	**up to $200 per calendar year**	**up to $200 per calendar year**	**up to $200 per calendar year**
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	$3,200/$6,400
Calendar Year Out-of-Pocket Maximum	Not Applicable	Not applicable	Not applicable	Unlimited
Coinsurance	60/40	Not covered	Not covered	60/40
Prescription Drugs	Cost Share + 40% to allowable	Not covered	Not covered	Not covered

2024 changes in red

This document provides an overview of your benefits only. Refer to your plan booklet for a complete description of benefits provided. The plan booklet will determine how benefits are paid.

SPOKANE TRANSIT AUTHORITY DENTAL BENEFITS Effective January 1, 2024 Carrier	Delta Dental of Washington
Benefit	Dental PPO
Class I - Diagnostic & Preventive Exams, Prophys, Fluoride, X-rays, Sealants	100%
Class II - Restorative Restorations, Endodontics, Periodontics, Oral Surgery	80%
Class III - Major Crowns, Dentures, Partials, Bridges and Implants	50%
Annual Maximum Per Person (January 1 - December 31)	$1,750
Deductible (Waived on Class I) Per person/per benefit period	$50 per person/$150 per family
Orthodontia Adults & Dependent Children Lifetime maximum per Enrollee	 50% $1,750 Lifetime Max
TMJ - B Nonsurgical Lifetime maximum	70% $500
Orthognathic Surgery Lifetime maximum	70% $5,000