Spokane Transit Authority - Plan Year January 2026 - December 2026
Medical

Benefits	2026				
				M&A, 3939, 1598 Only	
Carrier	**Premera Blue Cross**		**Kaiser Permanente**		
Plan Name	**Plan 1**		**Buy Up**	**Core Plan**	**CDHP**
Carrier Network	**Heritage Plus**		**Core HMO**	**Core HMO**	**Access PPO**
Network Tier	**IN**		**IN NETWORK ONLY**	**IN NETWORK ONLY**	**IN**	**OUT**
Individual Deductible	$250		$250	$350	**$1,700**	**$3,400**
Family Deductible	$750		$500	$700	**$3,400**	**$6,800**
Individual Out of Pocket Max	$2,000	n/a	$2,000	$2,000	$4,200	n/a
Family Out of Pocket Max	$4,000	n/a	$4,000	$4,000	$6,850	n/a
Coinsurance	15%	40%	None	None	15%	40%
Office Visit - PCP	15% after ded	40% after ded	$15 after ded	$20 after ded	15% after ded	40% after ded
Office Visit - Specialist	15% after ded	40% after ded	$30 after ded	$40 after ded	15% after ded	40% after ded
Telehealth	15% after ded	Not covered	Covered in full	Covered in full	15% after ded	40% after ded
Hospital - Inpatient	$200/day (up to $600/yr) +ded +coins	40% after ded	$150/day up to $750/admission after ded	$200/day up to $1,000/admission after ded	15% after ded	40% after ded
Outpatient Surgery	15% after ded	40% after ded	$150 after ded	$200 copay after ded	15% after ded	40% after ded
Emergency Room	$75 copay + 15% after ded		$250 after ded	$300 copay after ded	15% after ded	
Urgent Care Copay	15% after ded	40% after ded	$15/$30 after ded	$20/$40 after ded	15% after ded	40% after ded
Routine Lab/X-Ray	15% after ded	40% after ded	Ded then covered in full	Ded then covered in full	15% after ded	40% after ded
Advanced Imaging	15% after ded	40% after ded	$30 after ded	$40 after ded	15% after ded	40% after ded
Chiropractic	15% after ded	40% after ded	$15/$30 after ded	$20/$40 after ded	15% after ded	40% after ded
Chiro Visit Limit	10 visits per year		10 visits per year	10 visits per year	15 visits per year	
Vision Exam - Adult	No charge	40% after ded	$15/$30 after ded	$20/$40 after ded	Covered in full	
Vision Hardware	Covered in full up to $200	Not covered	Covered in full up to $200	Covered in full up to $200	Covered in full up to $200	
Benefit Frequency (Exam/Hardware)	1x per calendar year		1x per calendar year	1x per calendar year	1x per calendar year	
Pharmacy	**IN-NETWORK**		**IN-NETWORK**	**IN-NETWORK**	**IN-NETWORK**	
Rx Deductible	$100 Ind. / $300 Family		None	None	Subject to medical deductible	
Retail Rx - 30 days						
Generic / Tier 1	10% up to $75 (ded waived)		$5	$5	15% after ded (5% enhanced)	
Preferred Brand / Tier 2	30% up to $75		$20	$20	15% after ded (5% enhanced)	
Non-Preferred Brand / Tier 3	50%		$40	$40	15% after ded (5% enhanced)	
Specialty / Tier 4	Same as retail		50% up to $250	50% up to $250	Same as retail	
Mail Order Rx - 90 days	$10/$50/$100		$10/$40/$80/50% up to $750	$10/$40/$80/50% up to $750	2x enhanced benefit	

Spokane Transit Authority - Plan Year January 2026 - December 2026
Dental

Benefits	2026	
Carrier	**Delta Dental**	
Plan Name	**PPO Plan**	
Carrier Network	**Delta Dental PPO Network**	
Network Tier	**IN**	**OUT**
Deductible (Individual / Family)	$50/$150	
Annual Maximum	$2,000	
Preventive & Diagnostic	100%	80%
Basic	80% after deductible	70% after deductible
Major	50% after deductible	40% after deductible
Orthodontia	Adults and Children covered at 50%	
Orthodontia Lifetime Maximum	$2,000	
Additional Benefits / Notes		
Sealants	100%	
Fluoride	100%	
Endodontic Treatment	80% after deductible	
Periodontal Treatment	80% after deductible	
Composite Fillings	80% after deductible	
Implants	50% after deductible	
TMJ Coverage	70% up to $500 per year	