

SPOKANE TRANSIT AUTHORITY				
MEDICAL BENEFITS				1598, 3939 & Non-Reps Only
Effective January 1, 2025				
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) Annual Out-of-Pocket Maximum (Ind/Fam) Coinsurance (after deductible met)	\$250/\$750 \$2,000/\$4,000 85/15	\$250/\$500 \$2,000/\$4,000 No Plan Coinsurance	\$350/\$700 \$2,000/\$4,000 No Plan Coinsurance
Professional Services	Office Visit - Exams/Consultations Diagnostic X-Ray & Lab - Simple Major Imaging - MRI, CT, PET	15% after ded 15% after ded 15% after ded Covered in full	Primary Care \$15 Copay, after deductible Subject to deductible then 100% \$30 Copay after deductible Covered in full	Specialist \$30 Copay, after deductible Subject to deductible then 100% \$40 Copay after deductible Covered in full
Preventive Care				
Hospital Services	Inpatient Hospital Outpatient Hospital	\$200/day (up to \$600/yr) + ded + coins 15% after ded	\$150/day, up to \$750/admission after ded \$150 Copay after deductible	\$200/day, up to \$1,000/admission after ded \$200 Copay after deductible
Emergency Services	Emergency Room Urgent Care Ambulance	\$75 Copay after ded + coins 15% after ded 15% after ded	\$250 Copay after deductible \$15 Copay after deductible 20% (ded waived)	\$300 Copay after deductible \$20 Copay after deductible 20% (ded waived)
Other Services	Mental Health Benefits: Inpatient Care Outpatient Care Chiropractic	\$200/day (up to \$600/yr) + ded + coins 15% after ded 15% after ded (up to 10 visits per year)	\$150/day, up to \$750/admission after ded \$15 Copay after deductible \$15 Copay after deductible (up to 10 visits per year)	\$200/day, up to \$1,000/admission after ded \$20 Copay after deductible \$20 Copay after deductible (up to 10 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)
	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
	Routine Vision Care (1 visit PCY)	Covered in full	\$15 Copay (ded waived)	\$20 Copay (ded waived)
	Optical Hardware (Adult age 19+)	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
	Mail Order (up to 90 days)	\$10/\$50/\$100	\$10/\$40/\$80/50% up to \$750	\$10/\$40/\$80/50% up to \$750
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
	Calendar Year Out-of-Pocket Maximum	Not Applicable	Not applicable	Not applicable
	Coinsurance	60/40	Not covered	Not covered
	Prescription Drugs	Cost Share + 40% to allowable	Not covered	Not covered

2025 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, Partial, 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