HEALTH INSURANCE COMPARISON

MNA Home Care RN
January 1, 2025

UNIVERSITY OF MICHIGAN
HEALTH-SPARROW
MICHIGAN MEDICINE

In Network Services Covered	UM Health-Sparrow MNA PPO Plus	UM Health-Sparrow HDHP w/HSA		Blue Cross Blue Shield (BCBSM)
		SCN Network	SPN Network	
Annual Deductible	None	$1,650 single/ $3,300 family		In Network: $500/$1,000
Annual Max Out of Pocket	$1,800 single / $3,600 family	$3,000 single/ $6,000 family		$1,500 single / $3,000 family
Pairs With (must elect separately)	Medical Flexible Spending Acct	Health Savings Account		Medical Flexible Spending Acct
HSA Funding*	n/a	$750 single / $1,500 family		n/a
PCP Office Visit	$15/visit	No charge after deductible		$15/visit
Specialist Office Visit	$15/visit	No charge after deductible		$15/ visit
Maternity Care	100% covered	No charge after deductible		20% after deductible
Preventative Services	100% covered	No charge		100% covered
Inpatient Hospitalization	100% covered	No charge after deductible		20% after deductible
Outpatient Surgery	100% covered	No charge after deductible		20% after deductible
Lab and X-Ray	100% covered	No charge after deductible		20% after deductible
Emergency Room	$50/visit then 100% covered (waived if admitted)	No charge after deductible		20% after deductible
Urgent Care	$25/visit	No charge after deductible		$15/visit
Walk-In Care	$15/visit	No charge after deductible		$15/visit
Behavioral Health - IP	100% covered	No charge after deductible		20% after deductible
Behavioral Health - OP	$15/visit	No charge after deductible		$15/visit
Chiropractic/Osteopathic Manipulation	Not Covered	No charge after deductible; Combined maximum of 24 visits per member per year		20% after deductible; Combined maximum of 38 visits per member per year
Prescription Drug Coverage				
Drug Class	UM Health-Sparrow Pharmacy Only	After Deductible – ESI/Express Scripts Network, Including Sparrow Pharmacies		BCBSM Pharmacy
Generic	$7/ script	$10/ script		20% copay
Preferred	$20/ script	$40/ script		20% copay
Non Preferred	$30/ script	$80/ script		20% copay
Non Preferred Specialty	n/a	$100/ script		n/a
Monthly Rates				
Full Time				
Team Member Only	$163.86	$83.89		$216.75
Two Person	$392.62	n/a		$520.19
Team Member + Spouse	n/a	$167.78		n/a
Team Member + Child(ren)	n/a	$147.64		n/a
Family	$428.49	$231.53		$650.24
Part Time				
Team Member Only	$163.86	$83.89		$216.75
Two Person	$1,434.78	n/a		$1,733.99
Team Member + Spouse	n/a	$782.96		n/a
Team Member + Child(ren)	n/a	$615.18		n/a
Family	$1,634.04	$1,314.25		$2,384.24

This is a summary of ***in-network*** benefits provided by each carrier. Please refer to the Summary Plan Description for detailed information. Should any questions arise, contracts in effect will take precedence.

*HSA Annual Employer Contributions as a result of open enrollment, or continued participation in the Sparrow Health HSA plan, will be processed after the first pay period in January. All other HSA Employer Contributions will be prorated monthly based on benefit effective date and deposited within 30 days of the benefit election date. Please contact HR for further details. Team members electing HSA/FSA benefit options are responsible to manage compliance with IRS HSA/FSA rules. Note regarding contributions: Sparrow automatically makes a one-time annual employer contribution to your HSA account, pro-rated based on effective date. Team members are responsible for managing annual HSA/FSA contributions to ensure that the annual IRS limit is not exceeded. Team members who should find they have over-contributed in any calendar year would be responsible to request the HSA vendor to distribute any excess contributions from their account by April 15 of the subsequent year.

**Sparrow PPO and BCBSM have only Three tiers of coverage: Team member, Two Person and Family.

***If a covered member obtains a brand name drug when a generic drug equivalent is available, the member will pay the difference between the cost of the brand name drug and the cost of the generic, in addition to the copay. The cost difference will not apply to the deductible, or the annual maximum out-of-pocket.

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Out of Network Services Covered	UM Health-Sparrow MNA PPO Plus	UM Health-Sparrow HDHP w/HSA	Blue Cross Blue Shield (BCBSM)
	Out of Network	Out of Network	Out of Network
Annual Deductible	$300 single/$600 family	$3,000 single/ $6,000 family	$500 single/$1,000 family
Annual Max Out of Pocket	$1,800 single/$3,600 family	$6,250 single/ $12,500 family	$1,500 single/$3,000 family
PCP Office Visit	$30/visit after deductible	30% after deductible	$15/visit + 20% copay
Specialist Office Visit	$30/visit after deductible	30% after deductible	$15/visit + 20% copay
Maternity Care	30% coinsurance after deductible	30% after deductible	20% after deductible + 20% copay
Preventative Services	Not covered	Not covered	Not covered
Inpatient Hospitalization	30% coinsurance after deductible	30% after deductible	20% after deductible + 20% copay
Outpatient Surgery	30% coinsurance after deductible	30% after deductible	20% after deductible + 20% copay
Lab and X-Ray	30% coinsurance after deductible	30% after deductible	20% after deductible + 20% copay
Emergency Room	$50/visit then 100% covered (waived if admitted)	Same as Network	20% after deductible
Urgent Care	$45/visit	Same as Network	$15/visit + 20% copay
Walk-In Care	n/a	n/a	n/a
Behavioral Health - IP	30% coinsurance after deductible	30% after deductible	20% after deductible + 20% copay
Behavioral Health - OP (Therapy & Testing)	$30/visit after deductible	30% after deductible	$15/visit + 20% copay
Chiropractic/Osteopathic Manipulation	50% coinsurance after deductible, to limit of 12 visits/member/ year	30% after deductible Combined maximum of 24 visits/member/year	20% after deductible + additional 20% out-of-network coinsurance; Combined maximum of 38 visits/member/year
Prescription Drug Coverage			
Drug Class	No out of network pharmacy coverage unless emergent illness or urgent condition		NON BCBSM Pharmacy (mail order drugs not available)
Generic	n/a	.	20% copay + another 25%
Preferred	n/a	n/a	20% copay + another 25%
Non Preferred	n/a	n/a	20% copay + another 25%
Non Preferred Specialty	n/a	n/a	n/a
Monthly COBRA Rates			
Team Member Only	$928.52	$713.06	$1,105.40
Two Person	$2,224.85	n/a	$2,652.99
Team Member + Spouse	n/a	$1,426.11	n/a
Team Member + Child(ren)	n/a	$1,254.98	n/a
Family	$2,428.10	$1,968.03	$3,316.24

This is a summary of out of network benefits provided by each carrier. Please refer to the Summary Plan Description for detailed information. Should any questions arise, contracts in effect will take precedence.