Non Union Health Insurance Comparison - January 1, 2019

In Network Services Covered	Sparrow Health PPO **BASE**		Sparrow Health PPO **PLUS**		Sparrow Health HSA		Blue Cross Blue Shield (BCBS)
	SCN Network	SPN Network	SCN Network	SPN Network	SCN Network	SPN Network	
Annual Deductible	$500 single/ $1,000 family		$250 single/ $500 family		$1,500 single/ $3,000 family		At Sparrow: None In Network: $500/$1,000
Annual Max Out of Pocket	$3,000 single / $6,000 family		$6,000 single / $12,000 family		$3,000 single/ $6,000 family		$1,500 single /$3,000 family
HSA Funding*	n/a		n/a		$750 single / $1,500 family		
PCP Office Visit	$15/ visit	$20/ visit	No Charge	$15/ visit	No charge after deductible		$15/visit
Specialist Office Visit	$25/ visit	$40/ visit	$15/ visit	$30/ visit	No charge after deductible		$15/visit
Maternity Care	No charge after deductible		No charge after deductible		No charge after deductible		20% after deductible
Preventative Services	No charge		No charge		No charge		No charge
Inpatient Hospitalization	No charge after deductible		No charge after deductible		No charge after deductible		20% after deductible
Outpatient Surgery	10% after deductible		No charge after deductible		No charge after deductible		20% after deductible
Lab and X-Ray	10% after deductible		No charge after deductible		No charge after deductible		20% after deductible
Emergency Room	$250/ visit $150/visit at Clinton, Carson or Ionia		$200/ visit $100/visit at Clinton, Carson or Ionia		No charge after deductible		100% after deductible
Urgent Care	$25/ visit	$50/visit Non Sparrow UC	$25/ visit	$50/visit Non Sparrow UC	No charge after deductible		$15/visit
Fast Care	No Charge		No Charge		No charge after deductible		n/a
Behavioral Health - IP	No charge after deductible		No charge after deductible		No charge after deductible		20% after deductible
Behavioral Health - OP	$15/ visit	$20/ visit	No Charge	$15/ visit	No charge after deductible		$15/visit
Durable Medical Equipment	20% after deductible		No charge after deductible		No charge after deductible		20% after deductible
High Tech Imaging (CT, MRI)	$75/procedure after deductible		No charge after deductible		No charge after deductible		20% after deductible
Prescription Drug Coverage							
Drug Class	CVS/Caremark Network, including Sparrow Pharmacies		CVS/Caremark Network, including Sparrow Pharmacies		After Deductible CVS/Caremark Network, including Sparrow Pharmacies		BCBS Pharmacy
Generic	$10.00/script		$10.00/script		$10.00/script		20% copay
Preferred	$40.00/script		$40.00/script		$40.00/script		20% copay
Non Preferred	$80.00/script		$80.00/script		$80.00/script		20% copay
Non Preferred Specialty	$150.00/script		$80.00/script		$150.00/script		n/a
MONTHLY Rates							
Full Time							
Caregiver Only	$87.45		$142.88		$38.69		$143.59
Caregiver + Spouse	$174.90		$285.76		$77.38		$344.18
Caregiver + Child(ren**)	$153.92		$251.47		$68.09		$344.18
Family	$241.37		$394.35		$106.78		$432.15
Part Time							
Caregiver Only	$87.45		$142.88		$38.69		$143.59
Caregiver + Spouse	$712.11		$857.30		$425.58		$1,146.51
Caregiver + Child(ren)	$562.20		$685.84		$332.73		$1,146.51
Family	$1,186.86		$1,400.25		$719.62		$1,586.36

This is a summary of 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.

Non Union Health Insurance Comparison - January 1, 2019

Out of Network Services Covered	Sparrow Health PPO BASE	Sparrow Health PPO PLUS	Sparrow Health HSA	Blue Cross Blue Shield (BCBS)
	Non Network	**Non Network**	**Non Network**	**Non Network**
Annual Deductible	$2,000 single/ $4,000 family	$1,000 single/ $2,000 family	$3,000 single/ $6,000 family	$500 single/$1,000 family
Annual Max Out of Pocket	$6,000 single / $12,000 family	$6,000 single / $12,000 family	$6,250 single/ $12,500 family	$1,500 single / $3,000 family
HSA Funding*	n/a	n/a	$750 single / $1,500 family	n/a
PCP Office Visit	40% after deductible	30% after deductible	30% after deductible	$15/visit + 20% copay
Specialist Office Visit	40% after deductible	30% after deductible	30% after deductible	$15/visit + 20% copay
Maternity Care	40% after deductible	30% after deductible	30% after deductible	20% after deductible + 20% copay
Preventative Services (incl well baby)	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient Hospitalization	40% after deductible	30% after deductible	30% after deductible	20% after deductible + 20% copay
Outpatient Surgery	40% after deductible	30% after deductible	30% after deductible	20% after deductible + 20% copay
Lab and X-Ray	40% after deductible	30% after deductible	30% after deductible	20% after deductible + 20% copay
Emergency Room	$250/ visit	$200/ visit	Same as Network	100% after deductible
Urgent Care	$50/ visit	$50/ visit	Same as Network	$15/visit + 20% copay
Fast Care	n/a	n/a	n/a	n/a
Behavioral Health - IP	40% after deductible	30% after deductible	30% after deductible	20% after deductible + 20% copay
Behavioral Health - OP	40% after deductible	30% after deductible	30% after deductible	$15/visit + 20% copay
Durable Medical Equipment	50% after deductible	50% after deductible	30% after deductible	20% after deductible + 20% copay
High Tech Imaging (CT, MRI)	40% after deductible	30% after deductible	30% after deductible	20% after deductible + 20% copay
Prescription Drug Coverage				
Drug Class	No out of network pharmacy coverage unless emergent illness or urgent	No out of network pharmacy coverage unless emergent illness or urgent	No out of network pharmacy coverage unless emergent illness or urgent	NON BCBS Pharmacy
Generic	n/a	n/a	n/a	20% copay + another 25%
Preferred	n/a	n/a	n/a	20% copay + another 25%
Non Preferred	n/a	n/a	n/a	20% copay + another 25%
Non Preferred Specialty	n/a	n/a	n/a	n/a
MONTHLY COBRA Rates				
Caregiver Only	$637.15	$728.69	$394.63	$732.32
Caregiver + Spouse	$1,274.31	$1,457.40	$789.26	$1,755.30
Caregiver + Child(ren**)	$1,121.40	$1,282.51	$694.55	$1,755.30
Family	$1,758.55	$2,011.21	$1,089.18	$2,203.94

This is a summary of 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.

Non Union Dental Insurance Comparison
January 1, 2019

In Network Services Covered	Delta Dental		Midwestern Dental
	Base Plan	**Buy Up Plan**	
Annual Deductible	No deductible		No deductible
Preventative			
Exams	80% covered	100% covered	No charge
Cleaning	80% covered	100% covered	No charge
Xrays	50% covered	100% covered	No charge
Restorative			
Filling	50% covered	80% covered	No charge
Composite (Anterior only)	50% covered	80% covered	No charge
Composite (Posterior only)	50% covered	80% covered	Subject to Copay
Prosthetics			
Crowns	50% covered	50% covered	$100 Copay
Bridges (per unit)	50% covered	50% covered	$100 Copay
Dentures (each)	50% covered	50% covered	$100 Copay
Partial (each)	50% covered	50% covered	$100 Copay
Implants (crown and attachment)	50% covered	50% covered	Not covered
Oral Surgery			
Simple Extractions	50% covered	80% covered	No charge
Extraction Erupted Tooth	50% covered	80% covered	$10 Copay
Extraction Soft Tissue Impaction	50% covered	80% covered	$30 Copay
Extraction Partial Bony Impaction	50% covered	80% covered	$40 Copay
Extraction Complete Bony Impaction	50% covered	80% covered	$50 Copay
Endodontics			
Root Canal (single)	50% covered	80% covered	$30 Copay
Root Canal (double)	50% covered	80% covered	$50 Copay
Root Canal (Triple or more)	50% covered	80% covered	$100 Copay
Periodontics			
Gingivectomy	50% covered	80% covered	$50 Copay
Osseous Surgery	50% covered	80% covered	$100 Copay
Root Scaling	50% covered	80% covered	$15 Copay
Orthodontics			
Child (up to age 19)	50% covered	50% covered	$750 Copay
Adult (19 or older)	No coverage	No coverage	$1,300 Copay
Maximums			
Annual Maximum	$1,000	$1,500	n/a
Orthodontic Maximum	$1,500 lifetime	$1,500 lifetime	n/a
MONTHLY Rates			
Full Time	**Base Plan**	**Buy Up Plan**	
Caregiver Only	$1.17	$14.01	$0.84
Two Person	$4.50	$28.39	$3.28
Family	$9.13	$53.96	$5.66
Part Time			
Caregiver Only	$2.33	$15.17	$1.69
Two Person	$24.02	$47.91	$17.57
Family	$70.28	$115.11	$41.42
Monthly COBRA Rates			
Caregiver Only	$23.77	$36.86	$17.23
Two Person	$45.89	$70.26	$33.43
Family	$93.08	$138.80	$57.75

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.

Sparrow Vision Insurance Comparison
January 1, 2019

Vision Services Plan		
	Base Plan	**Buy Up Plan**
Annual Deductible	No deductible	
Preventative		
Vision Exams	100% Covered	100% Covered
Prescription Glasses	**$25 copay**	**$25 copay**
Frame	$100 allowance for frames $120 allowance for featured frames Included in above copay	$180 allowance for frames $200 allowance for featured frames Included in above copay
Lenses	Single vision, lined bifocal and lined trifocal. Polycarbonate Lenses for children Every calendar year Included in above copay	Single vision, lined bifocal and lined trifocal. Polycarbonate Lenses for children Every calendar year Included in above copay
Lens Enhancements	Scratch Resistent Coating - $0 copay Standard Progressive Lenses - $0 copay Premium Progressive Lenses - $95 - $105 copay Custom Progressive Lenses - $150 - $175 copay Anti-reflective coating - $41 - $85 copay	Scratch Resistent Coating - $0 copay Standard Progressive Lenses - $0 copay Premium Progressive Lenses - $25 copay Custom Progressive Lenses - $25 copay Anti-reflective coating - $25 copay
Contact Lenses (Instead of Glasses)	**Up to $60 copay**	**Up to $60 copay**
Contact Lenses	$115 allowance for contacts Contact lens fitting (fitting and evaluation) Every calendar year Included in above copay	$180 allowance for contacts Contact lens fitting (fitting and evaluation) Every calendar year Included in above copay
Diabetic Eyecare Plus Program	**$20 copay**	**$20 copay**
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma, and age related macular degeneration. Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply.	Services related to diabetic eye disease, glaucoma, and age related macular degeneration. Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply.
Extra Savings		
Glasses and Sunglasses	20% savings on additional glasses and sunglasses	20% savings on additional glasses and sunglasses
Retinal Screening	No more than a $39 copay on routine retinal screening	No more than a $39 copay on routine retinal screening
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities
MONTHLY Rates		
Full Time	**Base Plan**	**Buy Up Plan**
Caregiver Only	$0.00	$8.61
Two Person	$8.54	$24.40
Family	$14.43	$43.66
Part Time		
Caregiver Only	$0.00	$8.61
Two Person	$8.54	$24.40
Family	$14.43	$43.66
MONTHLY COBRA Rates		
Caregiver Only	$5.09	$13.87
Two Person	$13.80	$29.98
Family	$19.81	$49.62

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.