



**Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Aspire, Health Engagement Benefits for DTE**

Health Care Services	Enhanced Coverage Coverage / Limitations	Standard Coverage Coverage / Limitations
Benefit Period, Annual Deductible and Annual Co-Insurance Maximums		
Benefit Period	Calendar Year	Calendar Year
Annual Deductible	None	\$500 Individual; \$1,000 Family
Co-Insurance (amount member pays)	None	20%
Annual Co-Insurance Maximums	NA	\$1,000 Individual; \$2,000 Family
Preventive Services		
Preventive Office Visit/Physician Exam	Covered	Covered – Deductible does not apply
Well Baby Office Exam	Covered	Covered – Deductible does not apply
Routine Hearing Exam	Covered	Covered – Deductible does not apply
Routine Eye Exam	Covered	Covered – Deductible does not apply
Immunization	Covered	Covered – Deductible does not apply
Related Laboratory and Radiology Services	Covered	Covered – Deductible does not apply
Pap Smears and Mammograms	Covered	Covered – Deductible does not apply
Outpatient & Physician Services		
Personal Care Physician Office Visit	\$25 Copay	\$30 copay – Deductible does not apply
Specialty Physician Office Visit	\$25 Copay	\$45 copay – Deductible does not apply
Gynecology Office Visit	\$25 Copay	\$45 copay – Deductible does not apply
Audiology Office Visit	\$25 Copay	\$45 copay – Deductible does not apply
Eye Exam office Visit	\$25 Copay	\$45 copay – Deductible does not apply
Allergy Treatment and Injections	Covered	Plan Pays 80% after Deductible
Laboratory and Radiology Services	Covered	Plan Pays 80% after Deductible
Dialysis	Covered	Plan Pays 80% after Deductible
Chemotherapy	Covered	Plan Pays 80% after Deductible
Radiation Therapy	Covered	Plan Pays 80% after Deductible
Outpatient Surgery	Covered	Plan Pays 80% after Deductible
Chiropractic Office Visit and Related Services	Not Covered	Not Covered
Emergency/Urgent Care		
Emergency Room Services	\$100 Copay	\$100 Copay – Deductible does not apply
Urgent Care Facility Services	\$25 Copay	\$50 Copay – Deductible does not apply
Emergency Ambulance Services	Covered	Plan Pays 80% after Deductible
Inpatient Hospital Services		
Hospital Inpatient Stay in Semi-Private Room; Specialty Units as medically necessary; Physician Services; Surgery; Therapy; Laboratory; Radiology; Hospital Services and Supplies	Covered	Plan Pays 80% after Deductible
Bariatric Surgery & Related Services	\$1,000 copay	Plan Pays 80% after Deductible
Maternity Services		
Initial Prenatal Office Visit	\$25 copay	\$45 Copay – Deductible does not apply
Subsequent Prenatal and Postnatal Office Visits	\$25 copay	\$45 Copay – Deductible does not apply
Labor Delivery and Newborn Care	Covered	Plan Pays 80% after Deductible
Mental Health		
Inpatient Services	Covered	Plan Pays 80% after Deductible
Outpatient Services	\$25 Copay	\$30 Copay – Deductible does not apply
Chemical Dependency		
Inpatient Services	Covered	Plan Pays 80% after Deductible
Outpatient Services	\$25 copay	\$30 Copay – Deductible does not apply
Other Services		
Home Health Care	Covered	Plan Pays 80% after Deductible
Hospice Care	Covered; 210 days lifetime	Plan Pays 80% after Deductible; 210 days lifetime
Skilled Nursing care	Covered Up to 730 days, renewable after 60 days	Plan Pays 50% after Deductible; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	Covered Coverage provided for authorized equipment based on HAP's guidelines	Plan pays 50% after Deductible; Coverage provided for authorized equipment based on HAP's guidelines
Hearing Aid (Hardware)	Covered for authorized conventional hearing aids	Plan Pays 80% after Deductible; Covered for authorized conventional hearing aids
Vision Care Services (Hardware)	Not Covered	Not Covered
Physical, Speech and Occupational Therapy	Covered; Up to 60 combined visits per benefit period	Plan Pays 80% after Deductible; Up to 60 combined visits per benefit period
Voluntary Sterilizations	Covered	Plan Pays 80% after Deductible
Voluntary Termination of Pregnancy	Not Covered	Not Covered
Infertility Services	Covered; Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies	Plan Pays 50% after Deductible; Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Covered; One attempt of artificial insemination per lifetime	Plan Pays 50% after Deductible; One attempt of artificial insemination per lifetime
Pharmacy		
Generic / Preferred Brand / Non-Preferred Brand	\$10 / \$25 Copay Retail: 30-day supply for non-maintenance drugs at 1 copay; 90-day supply for eligible maintenance drugs at 2 copays. Mail Order: 90-day supply for both eligible maintenance and non-maintenance drugs at two copays.	\$15 / \$50 Copay Retail: 30-day supply for non-maintenance drugs at 1 copay; 90 supply for eligible maintenance drugs at 2 copays. Mail Order: 90-day supply for both eligible maintenance and non-maintenance drugs at two copays.
Benefit Riders	012, 013, 016, 039, 119, 124, 126, 299, 355, 476	013, 039, 070, 073, 124, 130, 134, 142, 148, 259, 299, 481, J11

1. Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.
 2. Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergent psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services.
 3. In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.