Summary of Comprehensive *Benefits – 2020 Plan Year*

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Unitarian Universalist Association — Medicare Supplement Comprehensive

Benefit	Coverage
General Provisions	
Benefit Period(1)	Calendar Year
Deductible (per benefit period)	
Individual	None
Family	None
Plan Pays – payment based on the plan allowance	100%
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period; Excludes copayment, deductibles, RX expenses and Amounts over UCR)	
Individual	None
Family	None
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits	100%
Primary Care Provider Office Visits	100%
Specialist Office Visits	100%
Urgent Care Center Visits	100%
Preventive Care(3)	
Routine Adult – Age 3 and up	
Physical exams	100%
Adult immunizations	100%
Colorectal cancer screening	100%
Routine gynecological exams, including a Pap Test	100%
Mammograms, annual routine and medically necessary	100%
Diagnostic services and procedures	100%
Routine Pediatric- Birth to age 3	
Routine physical exams	Not Covered
Pediatric immunizations	Not Covered
Diagnostic services and procedures	Not Covered
Hospital and Medical/Surgical Expenses (including Maternity)	
Hospital Inpatient	100%
Hospital Outpatient	
Maternity (non-preventive facility & professional services)	100%
Medical/Surgical Expenses (except office visits)	100%
Emergency Services	
Emergency Room Services	100%
Ambulance	100%
Therapy and Rehabilitation Services	
Physical Medicine	100%
Occupational Therapy	100%
Speech Therapy	100%
Spinal Manipulations	100%
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	100%
Mental Health/Substance Abuse	
Inpatient	100%
Inpatient Detoxification/Rehabilitation	
Outpatient	100%
Autism	Not Covered

Benefit	Coverage
Other Services	
Allergy Extracts and Injections	100%
Assisted Fertilization Procedures	Not Covered
Dental Services Related to Accidental Injury	100%
Diagnostic Services	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%
Durable Medical Equipment, Orthotics and Prosthetics	100%
Home Health Care	100%
Hospice	100%
Infertility Counseling, Testing and Treatment(2)	100%
Private Duty Nursing	Not Covered
Skilled Nursing Facility Care	100%
Transplant Services	100%
Precertification Requirements(3)	Yes

Questions? 1-800-796-6502

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(3) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.