Benefits Handbook Date October 1, 2024

# HMSA's Health Plan Hawaii Plus HMO

Marsh McLennan

# HMSA's Health Plan Hawaii Plus HMO

Health Plan Hawaii, a Health Maintenance Organization (HMO) Plan, offers comprehensive health services from participating health care providers. Generally, your care is fully covered after you pay a set COPAYMENT per visit. You select a primary care physician (PCP) who will manage your care and refer you to a specialist or other provider in the network if necessary. Except in an emergency, you do not receive benefits if you receive care outside of your health center.

References in this section to Marsh & McLennan Companies mean Marsh McLennan.

**SPD and Plan Document**

This section provides a summary of the HMSA's Health Plan Hawaii Plus HMO Plan (the "Plan") as of January 1, 2024.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

## A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this one. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

## Important Information About Your Personal Health Information

- The Company does not collect, maintain, or report on any personal health information pertaining to you or any covered dependents.
- As a participant in our health plan, your personal health information is protected by federal law.
- Our medical Third Party Administrators (or carriers with respect to the insured programs) are required to protect your personal health information in accordance with federal law and data privacy agreements with the Company and/or plan fiduciaries.
- Please note that states seeking to prohibit or limit certain services covered under Company-sponsored plans might attempt to challenge your right to privacy under federal law. If a state's legal challenge is successful, there may be legal consequences associated with you procuring a service covered under a Company-sponsored plan that is or may become prohibited or limited under state law. If you have any questions regarding potential risks, please seek professional legal advice.

## In This Section See Page

# The Plan at a Glance

This Plan helps you and your family pay for medical care. You may pay a copayment for certain services. The chart below contains some important Plan features and coverage amounts. For more information, see the **HMSA's Health Plan Hawaii Plus Health Maintenance Organization (HMO) Guide to Benefits**. Go to Colleague Connect (**https://mmcglobal.sharepoint.com/sites/home**). Click **Pay & Benefits**, under **Find a document**, select **Search all documents**.

| Plan Feature | Coverage Amount |
|---|---|
| **Deductible** | ▪ Employee: None<br>▪ Family members: None |
| **Medical Out-of-pocket Maximum** | ▪ Employee $2,500<br>▪ Family maximum $7,500 |
| **Prescription Drug Out-of-pocket Maximum** | ▪ Employee $3,600<br>▪ Family maximum $4,200 |
| **Preventative Care** | ▪ Well child care office visit & immunizations: Covered at 100%<br>▪ Well child lab: Covered at 100%<br>▪ Routine physical and GYN exam: Covered at 100%<br>▪ Routine mammography: Covered at 100%<br>▪ Routine vision exam: $20 copay (1 per year) |
| **Medical Services** | ▪ Physician office/outpatient hospital visit: $20 copay/visit<br>▪ Specialist visit: $20 copay/visit<br>▪ Urgent care center: $20 copay/visit<br>▪ Emergency room: $100 copay/visit, State-wide & Participating BlueCard Providers<br>▪ INPATIENT hospitalization: Covered at 90%<br>▪ Inpatient lab and X-ray: Covered at 90%<br>▪ OUTPATIENT lab and X-ray: $10 copay for X-ray and blood work; Imaging and diagnostic tests covered at 80%<br>▪ Outpatient surgical care: $20 copay/visit |

| Plan Feature | Coverage Amount |
|---|---|
| **Retail Prescription Drugs** | **In-Network:**<br>▪ **Generic:** $7 copayment, 30-day supply*<br>▪ **Preferred Brand-Name:** $30 copayment, 30-day supply*<br>▪ **Other Brand-Name:** $75 copayment ($30 plus a $45 other brand name cost share), 30-day supply*<br>▪ **Preferred Specialty:** $100 copayment, 30-day supply<br>▪ **Other Brand-Name Specialty:** $200 copayment, 30-day supply<br>***Maintenance Prescriptions:** In addition to the mail order option for obtaining maintenance prescriptions, you can also go to any pharmacy in the "90 Day at Retail" pharmacy network to obtain maintenance prescriptions. Retail benefit limited to a 30-day supply for preferred specialty and other brand-name specialty.<br><br>**Out-of-Network:**<br>▪ **Generic:** Plan pays 80% after the $7 copayment for up to a 30-day supply<br>▪ **Preferred Brand-Name:** Plan pays 80% after the $30 copayment for brand name prescriptions up to a 30-day supply<br>▪ **Other Brand-Name:** Plan pays 80% after the $75 copayment ($30 plus a $45 other brand name cost share) for up to a 30-day supply<br>▪ **Preferred Specialty:** Not Covered<br>▪ **Other Brand-Name Specialty:** Not Covered |
| **Mail-order Prescription Drugs** | **In-Network**<br>▪ **Generic:** $11 copayment, 90-day supply<br>▪ **Preferred Brand-Name:** $65 copayment, 90-day supply<br>▪ **Other Brand Name:** $200 copayment ($65 plus $135 other brand name cost share), 90-day supply<br>▪ **Diabetic Supplies:** Non -Preferred Formulary diabetic supplies $65 copayment, 90-day supply (No copayment for Preferred Formulary diabetic supplies)<br>▪ **Preferred Specialty:** Not Covered<br>▪ **Other Brand-Name Specialty:** Not Covered<br>**Out-of-Network: Not covered** |
| **Contact Information** | Contact for Medical Service and Prescription Drug Coverage:<br>HMSA (Claims Administrator and Pharmacy Benefit Manager)<br>Phone: +1 808 948 6372<br>Website: www.hmsa.com<br>Marsh McLennan does not administer this plan. HMSA's decisions are final and binding. |

# Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Eligibility for this Plan is also based on your resident zip code.

### Retiree Eligibility

Certain retirees who are not yet deemed to be eligible for MEDICARE may also be eligible for coverage under this plan. For information on the eligibility requirements, how to participate and the cost of coverage see the *Participating in Pre-65 Retiree Medical Coverage* section.

## Enrollment

To participate in this plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment (generally in October with respect to coverage for the following calendar year)
- within 30 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this plan.

Enrollment procedures for you and your ELIGIBLE FAMILY MEMBERS are described in the *Participating in Healthcare Benefits* section.

## Cost of Coverage

You and the Company share the cost of coverage for both you and your ELIGIBLE FAMILY MEMBERS.

The cost of your coverage depends on the level of coverage you choose. The cost may change each year.

You can choose from four levels of coverage. The table below shows the cost for each coverage level for eligible employees of Marsh McLennan and Marsh & McLennan Agency LLC – Corporate (MMA-Corporate), Marsh & McLennan Agency LLC – Alaska (MMA-Alaska), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast), Security Insurance Services of Marsh & McLennan Agency LLC and Marsh & McLennan Agency LLC, Private Client Services – National Region (MMA PCS – National).

| Coverage Level | Semi-monthly Cost | Weekly Cost |
|---|---|---|
| Employee Only | $21.87 | $10.09 |
| Employee + Spouse/Domestic Partner | $489.01 | $225.69 |
| Employee + Child(ren) | $384.52 | $177.47 |
| Employee + Family | $704.29 | $325.06 |

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

### *Imputed Income for Domestic Partner Coverage*

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

**Section 152 Dependents**

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

The table below shows the imputed income amounts for eligible employees of Marsh McLennan and MMA-Corporate, MMA-Alaska, MMA-Northeast, Security Insurance Services of Marsh & McLennan Agency LLC and Marsh & McLennan Agency LLC, Private Client Services – National Region (MMA PCS – National).

| **Imputed Income for Domestic Partner Coverage Hawaii HMO Plan** | | |
|---|---|---|
| **Coverage Level** | **Semi-monthly** | **Weekly** |
| **Employee + Domestic Partner (non-qualified)** | $507.71 | $234.32 |
| **Employee + Child(ren) (non-qualified)** | $362.65 | $167.37 |
| **Employee + Domestic Partner (non-qualified) & Child(ren)** | $543.98 | $251.07 |
| **Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) non-qualified)** | $906.63 | $418.44 |

## ID Cards

You will be sent your ID card(s) within two to four weeks of your enrollment.

You may request additional ID cards directly from the Claims Administrator.

The ID card will provide instructions on how to select your physician.

# How the Plan Works

This Plan helps you and your family pay for medical care. You may pay a COPAYMENT for certain services. Generally, your care is fully covered after you pay a set copayment per visit. You select a primary care physician (PCP) who will manage your care and refer you to a specialist or other provider in the network if necessary. Except in an emergency, you do not receive benefits if you receive care outside the network.

For more information, including coverage criteria, other limitations of covered services, and excluded services, see the **HMSA's Health Plan Hawaii Plus Health Maintenance Organization (HMO) Guide to Benefits**. Go to Colleague Connect (**https://mmcglobal.sharepoint.com/sites/home**). Click **Pay & Benefits**, under **Find a document**, select **Search all documents**.

Certain expenses not covered by the Plan, such as copayments and services that are not covered, may be reimbursed through a Health Care Flexible Spending Account.

Some services have specific limits or restrictions; see individual service for more information.

Benefits are only paid for medically necessary charges or for specified wellness care expenses.

Preauthorization may be required in order to receive coverage for certain services.

# Filing a Claim

If you use an in-network provider, in almost all cases, you do not have to file a claim form. In the very rare cases that you might need to file a claim, contact the Claims Administrator.

If you receive services from a provider who does not participate in the network, those services will not be covered. Out-of network benefits are not covered under the Plan except in an emergency.

## *Appealing a Claim*

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

# Glossary

## Actively-At-Work

As a new hire, you are "Actively-At-Work" on the first day that you begin fulfilling your job responsibilities with the Company at a Company-approved location. If you are absent for any reason on your scheduled first day of work, your coverage will not begin on that date. For example, if you are scheduled to begin work on August 3rd, but are unable to begin work on that day (e.g., because of illness, jury duty, bereavement or otherwise), your coverage will not begin on August 3rd. Thereafter, if you report for your first day of work on August 4th, your coverage will be effective on August 4th.

## After-tax (Post-tax) Contributions

Contributions taken from your paycheck after taxes are withheld.

## Before-tax (Pre-tax) Contributions

Contributions taken from your paycheck generally before Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state, and other income taxes are withheld.

## Claims Administrator/Pharmacy Benefit Manager

Vendor that administers the Plan and processes claims; the vendor's decisions are final and binding.

## Consolidated Omnibus Budget Reconciliation Act (COBRA)

A Federal law that lets you and your eligible family members covered by a group health plan extend group health coverage temporarily, at their own expense, at group rates plus an administrative fee, in certain circumstances when their coverage would otherwise end due to a "qualifying event", as defined under COBRA.

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

## Coordination of Benefits

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health treatment costs. If this is the case, benefits from this plan will be "coordinated" with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from this plan are coordinated with "no fault" automobile insurance and any payments recoverable under any workers' compensation law, occupational disease law or similar legislation.

## Copayment

The flat dollar amount you pay for a certain type of health care expense.

## COVERED SERVICE(S)

Medically necessary health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

Covered health services must be provided:

- when the plan is in effect
- prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description
- only when the person who receives services is a covered person and meets all eligibility requirements specified in the plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or group studies.

The Claims Administrator determines only the extent to which a service or supply is covered under the plan and not whether the service or supply should be rendered. The coverage determination is made using the descriptions of covered charges included in this section and the Claims Administrator's own internal guidelines. The decision to accept a service or obtain a supply is yours.

## DEDUCTIBLE

The amount of out-of-pocket expenses you must pay for covered services before the plan pays any expenses.

## DURABLE MEDICAL EQUIPMENT

Durable medical equipment is equipment that is:

- for repeated use and is not a consumable or disposable item,
- used primarily for a medical purpose, and
- appropriate for use in the home.

## ELIGIBLE FAMILY MEMBERS

To cover an eligible family member, you will be required to certify in the Aptia365 Benefits Enrollment Website that your eligible family member meets the eligibility criteria as defined below.

Spouse/Domestic Partner means:

Adding a spouse or same gender or opposite gender domestic partner to certain benefits coverage is permitted upon employment or during the Annual Enrollment period for coverage effective the following January 1st if you satisfy the plans' criteria, or immediately upon satisfying the plans' criteria if you previously did not qualify.

*Spouse / Domestic Partner*

- You have already received a marriage license from a US state or local authority, or registered your domestic partnership with a US state or local authority.

*Spouse Only*

- Although not registered with a US state or local authority, your relationship constitutes a marriage under US state or local law (e.g. common law marriage or a marriage outside the US that is honored under US state or local law).

*Domestic Partner Only*

- Although not registered with a US state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - be at least 18 years old
  - not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - have agreed to share responsibility for each other's common welfare and basic financial obligations
  - not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Marsh McLennan reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

Under the HMSA's Health Plan Hawaii Plus HMO, Child/Dependent Child means:

- your biological child
- a child for whom you and your spouse are the legally appointed guardian with full financial responsibility
- the child of a domestic partner
- your stepchild
- your legally adopted child or a child or child placed with you for adoption.

**Note:** Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

**Note:** While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify the relationship (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility - that is, you or your spouse claims them as a dependent on your annual tax return.

## Eligible Marsh & McLennan Companies Employees (other than MMA)

As used throughout this document, "Marsh & McLennan Companies Employees (other than MMA)" are defined as employees classified on payroll as US regular employees of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries).

## Eligible MMA Employees

As used throughout this document, "MMA Employees" are defined as employees classified on payroll as a US regular employee of Marsh & McLennan Agency LLC – Corporate (MMA-Corporate), Marsh & McLennan Agency LLC – Alaska (MMA-Alaska), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast), Security Insurance Services of Marsh & McLennan Agency LLC or Marsh & McLennan Agency LLC, Private Client Services – National Region (MMA PCS – National).

## Eligible Retiree

An employee is eligible for coverage under this plan if he/she is a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries) who terminates employment with five or more years of vesting service at age 55 or later, or at age 65 and eligible for active employee medical coverage at retirement or is a current retiree (under or over age 65) enrolled in retiree medical coverage.

When you or a covered family member reach age 65 or are deemed to be eligible for Medicare, you and your covered family members are no longer eligible for coverage under the Pre-65 Retiree Medical Plan.

## Evidence of Insurability (EOI)

Evidence of Insurability (EOI) is proof of good health and is generally required if you do not enroll for coverage when you first become eligible. If the coverage level you are requesting requires such evidence or if you are increasing coverage. Establishing EOI may require a physical examination at the employee's expense. The EOI must be provided to and approved by the insurer/vendor before coverage can go into effect.

## Emergency Room Coverage

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part.

Some examples of emergencies include:

- heart attack, suspected heart attack or stroke
- suspected overdose of medication
- poisoning
- severe burns
- severe shortness of breath
- high fever (103 degrees or higher), especially in infants
- uncontrolled or severe bleeding
- loss of consciousness
- severe abdominal pain
- persistent vomiting
- severe allergic reactions.

The plan covers emergency services necessary to screen and stabilize a member when:

- a primary care physician or specialist physician directs the member to the emergency room
- a plan representative (employee or contractor) directs the member to the emergency room
- the member acting as a prudent layperson and a reasonable person would reasonably have believed that an emergency condition existed.

### Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

### Global Benefits Department

Refers to the Global Benefits Department, located at 1166 Avenue of the Americas, 31st Floor, New York, NY 10036.

### Health Insurance Portability and Accountability Act (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans concerning the use and disclosure of individual health information.

### Hospice

A hospice is an institution that provides counseling and medical services that could include room and board to terminally ill individuals. The hospice must have required state or governmental Certificate of Need approval and must provide 24 hour-a-day service under the direct supervision of a physician. The staff must include a registered nurse, a licensed social service worker and a full-time claims administrator. If state licensing exists, the hospice must be licensed.

### In-network Providers

Preferred health care providers who have agreed to charge reduced fees to members.

## Inpatient

A covered individual who is admitted to a covered facility for an overnight stay, either by a physician or from the emergency room.

## Medicare

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

## Non-custodial Care

Non-custodial care is skilled nursing care or physical, occupational, or speech therapy visits rendered by an agency or organization licensed or certified as a home health care agency in the state where the health care is given.

## Out-of-network Providers

Health care providers who are not in-network providers and do not charge reduced fees.

## Outpatient

Treatment/care received by a covered individual at a clinic, emergency room or health facility without being admitted as an overnight patient.

## Out-of-pocket Expenses

The maximum amount you have to pay (excluding your contributions to participate in the plan) toward the cost of your medical care in the course of one year. There are some services and charges that do not count towards the out-of-pocket maximum, such as amounts exceeding plan limits, amounts exceeding the network negotiated price for prescription drugs, amounts your physician or health care provider may charge above the reasonable and customary charge, and speech therapy for a child.

## Preauthorization/Precertification/Utilization Review

A review service that helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

## Predetermination of Benefits

This feature helps you estimate how much the Plan may pay (subject to your deductible and Plan maximum at the time the estimate is provided) before you begin treatment. It is intended to avoid any misunderstanding about coverage or reimbursement, and it is not intended to interfere with your course of treatment.

## Pre-existing Condition

A health problem you had and received treatment for before your current benefit elections took effect.

## Prescription Drugs

- **Preferred Brand Name (Preferred) Prescription Drugs.** A comprehensive list of preferred brand-name drug products that are covered under the plan. Preferred drugs are selected based on safety, effectiveness, and cost.
- **Generic Prescription Drugs.** Prescription drugs, whether identified by chemicals, proprietary or non-proprietary name, that are accepted by the FDA as therapeutically effective and interchangeable with drugs having an identical amount of the same active ingredient as its brand name equivalent.
- **Other Brand Prescription Drugs.** Prescription drugs that do not appear on the preferred brand list are considered non-formulary or non-preferred; these drugs may either be excluded from coverage or may cost more.

## Preventive/Wellness Care

Annual examinations or routine care covered under the plan; care that prevents or slows the course of an illness or disease or care that maintains good health.

## Prior Approval

Prior approval helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

## Qualified Family Status Change (Status Change, Qualified Change in Family Status)

An event that changes your benefit eligibility. For example, getting married and having a child or your spouse or dependent lose other coverage. You can make certain changes to your before-tax benefit elections that are due to and consistent with the change in family status.

## Qualified Medical Child Support Order (QMCSO)

A court order, judgment or decree that (1) provides for child support relating to health benefits under a plan with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law or (2) is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act. A QMCSO is usually issued requiring you to cover your child under your health care plan when a parent receiving post-divorce custody of the child is not an employee.

## Qualifying Event

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

## Reasonable & Customary (R&C) Charges/Fees

Charges/fees that do not exceed the prevailing charges for comparable services in your provider's area. The Claims Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located. The plan's reasonable and customary guidelines include up to the 90th percentile of providers' charges in the area.

The plan does not cover amounts charged by providers in excess of the reasonable and customary charge for any service or supply. The Claims Administrator regularly reviews the reasonable and customary charge schedule. To confirm whether your provider's charges are within the reasonable and customary limit, obtain a Predetermination of Benefits.

**Urgent Care Services**

Urgent care is non-preventive or non-routine health care services which are required in order to prevent serious deterioration of a member's health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

The services must be a covered service under the contract to be subject to reimbursement. Routine care, including follow-up care, is not covered as urgent care.

## Waiting Period/Elimination Period

The amount of time you must wait before being able to participate in a plan.