Corpsmember Health Plan — Medical, Prescription & AD&D

The CorpsNetwork
Strengthening America through service and conservation

September 1, 2022 to August 31, 2023
Medical by Cigna, AD&D by Gerber
Medical Group Number: 3338030

Cigna

Benefit / Provision	Cigna Provider	Out-of-Network
Deductible Per Plan Year (September 1 – August 31**)** (Applies to all services except in-network Preventive and Office Visits)	$175	$350
Out-of-Pocket Maximum (Includes Deductible)	$2,750	$5,500
Lifetime Maximum	Unlimited	
Preventive (Routine) **Care**	100% (no deductible)	50%
Prescription Drugs (Express Scripts Value List)*	80%	50%
Telehealth (MDLive; includes Behavioral Health)	(no deductible) $5 copay	
Office Visits Primary Care Tier 1 Specialist (see coverage checklist for Tier 1 access) Non-Tier 1 Specialist	(no deductible) $10 copay $10 copay $20 copay	50%
Professional Services (Surgery, Lab & X-Ray)	80%	50%
Urgent Care	$20 co-pay, then covered at 80%	
Ambulance	80%	
Emergency Room	$100 co-pay, then covered at 80%	
Hospital (Inpatient pre-authorization required)*	80%	50%
Mental Health Inpatient Office Visit	 80% $10 copay	 50% 50%
Chemical Dependency (Inpatient and Outpatient)	80%	50%
Outpatient Rehabilitation - 20 visits per Plan Year (Physical, Speech, Occupational, Cardiac therapies and Chiropractic)	80%	50%
Employee Assistance Program (EAP)	24/7 telephonic support, 3 free face-to-face visits for life events **Call 877-231-1492**	
AD&D	$10,000	
Monthly Rate (Paid by sponsoring program)	$416.55*	

Cigna requires pre-authorization for all inpatient hospital, some outpatient procedures and certain drugs.

Benefits end at the close of the month in which active service concludes. Members may get free assistance in finding individual health coverage (and potentially qualifying for credits) through **Via Benefits** (see separate flyer).

This is a summary of benefit coverage. Further detail can be found by contacting Cigna. Out-of-network coverage is based on Cigna's maximum allowable charge and may result in additional out-of- pocket expenses.

The Corps Network Health Plan
Cigna Mental Health Services

Mental health is an important part of your overall health. Recognizing this, The Corps Network Health Plan offers several ways of accessing mental health services through Cigna.

General Mental Health Services

MyCigna.com

Search for a behavioral health provider to schedule an appointment either in-person OR virtually (if offered by the clinician).

How to Access:

- Visit myCigna.com, go to "Find Care & Costs"
  - Search by "counselor" or "virtual counselor" under Doctor by Type
  - You can also filter by mental health condition type
- Call the number on the back of your Cigna ID card

MDLive

Schedule a virtual care provider appointment via the MDLIVE app/website.

How to Access:

https://www.mdlive.com/cigna
myCigna.com
888.726.3171

Cigna Total Behavioral Health EAP

Three free face-to-face visits with an EAP provider.

How to Access:

- Visit myCigna.com, go to "Find Care & Costs"
  - Search by "counselor" or "virtual counselor" under Doctor by Type
  - Filter by 'EAP' benefits
- Call the number on the back of your Cigna ID card

Talkspace

Virtually connects you with a therapist either via video or private text messaging.

How to Access:

https://www.talkspace.com/cigna
myCigna.com

Ginger

Virtual access to coaches, therapists and psychiatrists from your smartphone via chat, self-guided content and video-based therapy for the cost of an office visit.

How to Access:

- Visit ginger.com/cigna and download the app
- Email help@ginger.com

Condition Specific Support

Through myCigna.com:

Meru Health- 12 week virtual counseling for depression, anxiety or burnout

MAP – Peer support recovery from substance abuse disorder

NOCD – Virtual therapy for OCD

Tools and Resources

Through myCigna.com:

Happify – app-based self-directed program with activities, science-based games and meditation designed to help members reduce stress and anxiety and boost resilience.

iPrevail – app-based digital therapeutics program with interactive video lessons and one-on-one coaching to help with depression and anxiety.

Your Coverage Checklist Plan Year 2022 - 2023

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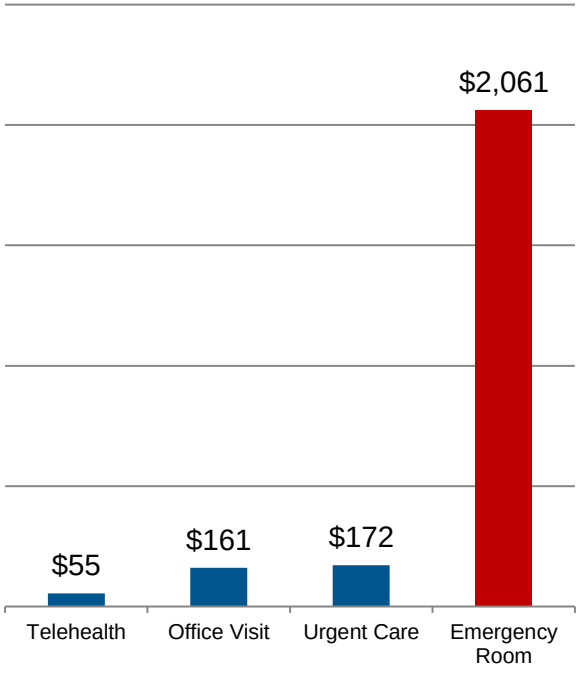
Cigna.

- ✓ **Review your Benefit Summary and Welcome Packet**
  - Know your benefits before you use them
- ✓ **Find your virtual ID card on the myCigna app**
- ✓ **Locate Cigna Tier 1, Preferred Providers and select a Primary Care doctor**
  - Click on “Find a Doctor” at myCigna
  - For high quality providers with a lower copay, look for the Tier 1 note as you search
- ✓ **Pre-register for convenient Telehealth on myCigna.com**
  - Phone or chat doctor visits
  - MDLive for medical
  - Behavioral health (under Specialty in the Behavioral Directory link)
- ✓ **Know your options for care when you need it – and choose the most appropriate**
  - Nurseline — Can help determine appropriate place to seek care
  - Virtual Care – Office visits from the convenience of your computer or phone
  - Telehealth MDLive— Convenient and inexpensive for behavioral health and routine ailments
  - Doctor’s Office — Continuity of care from routine to chronic
  - Urgent Care — Quick access in and out of traditional office hours
  - Emergency Room — Most expensive but important for serious situations
- ✓ **Get your Preventive Care**
  - Routine care is free from a Preferred Provider
- ✓ **Questions? Call Cigna at the number on your ID card**

Get started!

1. **Launch** the myCigna app or go to the myCigna.com website and select “Register Now”
2. **Enter** your requested information
3. **Confirm** your identity
4. **Create** your security information and provide your email address
5. **Review** and submit

Average Cost Per Visit



- Based on data from 2021
- Telehealth based on regular medical services received through MDLIVE

Eligibility Definitions

The Corps Network Health Plan is an insurance program with certain rules required in order to maintain cost efficiency and benefit levels. We rely on each member program to understand and adhere to the rules and standards that support the plan. Following are key definitions and some frequently asked questions regarding eligibility of corpsmembers:

Definitions

Eligible Person - An Active Corps Network Organizational Corpsmember or AmeriCorps Member contracted by a Corps Network Member Program to perform specific duties in service to the community. An Eligible Person may be a foreign national, but there is no coverage for any expenses incurred by an insured outside the United States, its territories and possessions.

Corps Network Organizational Corpsmember - a participant (AmeriCorps Member or Non-AmeriCorps Corpsmember) who is enrolled for a limited term of service (usually up to one year) with a Corps Network Organizational Member Corps to perform duties under the instruction and direction of that Corps.

AmeriCorps Member - a participant currently enrolled and active in AmeriCorps through an AmeriCorps program that is an Affiliate or Basic Member of The Corps Network or through an Affiliate State Commission Corps Network Member.

Eligibility FAQs — Medical

When does a corpsmember's coverage begin?

The plan is designed to allow coverage beginning on the corpsmember's first day of active service.

When does a corpsmember's coverage end?

A corpsmember's coverage ends on the last day of the month in which their active service terminates.

What happens to coverage during a medical suspension?

If a corpsmember's service is suspended for medical reasons, the plan may continue in place until the last day of the month after two months of suspension. Premium must be paid by the program without interruption. SMIC, the plan administrator, must be notified of any corpsmember that is covered during a medical suspension.

Is premium pro-rated?

If a member's start date occurs in the first 15 days of the month, premium is owed for the entire month. If this date falls in the last 15 days of the month, premium is not owed until the first of the following month. The initial payment will be for an entire month's premium.

A full month of premium is owed for the month in which a corpsmember's active service ends as coverage continues until the end of that month.

Eligibility FAQs — Medical

Can the corpsmember be charged for any portion of their premiums?

The Corps Network Health plan requires 100% premium contribution on the part of the program. Therefore, premium cannot be billed to the corpsmember. The program is responsible for the full cost of all its corpsmembers' coverage.

Do all corpsmembers need to be enrolled in the plan?

The plan requires 100% participation of all eligible corpsmembers. The only valid reason for an eligible member to waive benefits under The Corps Network Health Plan is if they have coverage from another source (e.g., spouse, parent). The corpsmember must provide documentation that he/she is covered elsewhere and complete a signed waiver form which is kept on file at the program.

This policy does not bar members from being enrolled on another policy (through another source) in addition to The Corps Network Health plan. The Corps Network plan will pay primary to most other insurance.

How do the eligibility rules work for dental/vision?

The program decides whether they want to purchase the dental/vision coverage for their corpsmembers. If the program enrolls in the dental/vision coverage for their corpsmembers, anyone enrolled in the medical must also be enrolled in the dental/vision and vice versa.

Can a corpsmember who waived coverage be enrolled on The Corps Network plan later?

If the waiving corpsmember loses other coverage, the program is required to enroll him/her onto The Corps Network Health Plan in order to comply with the participation rules.

Can a corpsmember cover any dependents under this policy?

No. The plan is designed to cover corpsmembers only.

What about COBRA/Continuation?

COBRA is Employer/Employee legislation and corpsmembers are not considered employees. Therefore, COBRA will not be offered. In certain states, however, Cigna is required to offer continuation of the medical plan to exiting members, and eligible members will receive a letter from them.

Eligibility FAQs — Medical

Are there coverage options for corpsmembers when their service ends?

Yes. Via Benefits will contact corpsmembers prior to their service end date with the opportunity to use their free platform to shop for and purchase a post-service individual medical plan.

What if our program has members returning for a second year?

Your program may choose to allow "Gap" coverage for up to 2 months between one service term and the next when a corpsmember commits to a second term of service. If you require the returning member to pay for "Gap" coverage, you must collect the premium from them and remit to SMIC as part of the normal billing process.

What options are available to corpsmembers for health coverage when their active service ends and they are no longer eligible for The Corps Network plan?

Losing coverage through completion of AmeriCorps service triggers a special enrollment period. The member has 60 days from the date coverage ends to sign up for a plan through the federal healthcare marketplace or applicable state exchange.

In some states, Cigna is required to offer continuation coverage to exiting members. Cigna will send a letter directly to exiting corpsmembers in the affected states.

Is the Corps Network Plan Compliant with the Affordable Care Act and does it provide Minimum Essential Coverage?

As of September 1, 2014 and thereafter, The Corps Network Plan is compliant with the Affordable Care Act (ACA). There are no caps on lifetime benefits or essential benefits and the plan qualifies as Minimum Essential Coverage.

Can our program offer The Corps Network Plan and a Reimbursement Option for coverage through a state or federal marketplace plan?

No. In order to use The Corps Network Plan, a program must attest to the fact that there is no other program sponsored coverage. This includes reimbursement of the member's share of individual policy premiums on the marketplace. A program cannot offer both options to members.

Will Programs be assisted by the plan in meeting the ACA reporting requirements?

Since AmeriCorps defines corpsmembers as volunteers, we believe that programs are not required to provide a 1095c to those covered by this plan. If you decide to provide this form to your covered members anyway, SMIC can assist with a report that reflects who was actually covered during the year, but of course, not all who were offered coverage. Form 1094c must be submitted to the IRS. This form will be submitted to the IRS by Cigna.

Eligibility FAQs — Medical

Does The Corps Network Plan satisfy our obligation as an AmeriCorps grantee?

According to the 2015 Terms and Conditions for AmeriCorps State and National Grants, a program may satisfy its requirement related to health insurance for full time members by purchasing a private policy. The policy must be considered Minimum Essential Coverage and meet the requirements of the Affordable Care Act. The Corps Network Plan meets these standards and satisfies a program's obligation.

Who will answer any additional questions that I have?

The broker for The Corps Network plan is Willis Towers Watson. Please email Julie Nelson at Julie.nelson@wtwco.com with questions.

Note About Plan Administration

Once your Program is set up for coverage at SMIC, all adds, terminations and changes of corpsmember information will all be done by the Program Administrator on SMIC's online enrollment portal.

Health Plan Contact List

Organization	Primary Contact
The Corps Network The Corps Network is a national membership organization providing various services to its member corps, including sponsorship of The Corps Network Health Plan. The Corps Network Health Plan complies with all AmeriCorps/CNCS requirements. Service organizations must be members in good standing with The Corps Network to be eligible for the plan.	**Rachael Zwerin**, Member Services Associate *Phone:* 1-202-495-2579 *Email:* *rzwerin*@corpsnetwork.org *Website:* www.corpsnetwork.org
Willis Towers Watson (WTW) WTW, as the broker for The Corps Network, created the Health Plan in February of 1992. They provide ongoing management of the insurance program. WTW is also available for general questions and concerns from program administrators.	**Julie Nelson**, Associate Director *Email:* julie.nelson@wtwco.com
CIGNA – Group Number 3338030 Cigna administers the medical/prescription drug coverage. That includes claims processing and customer service, as well as virtual ID cards.	**Customer Service (Medical/Prescription)** *Phone:* 1-800-244-6224 *Website:* www.cigna.com or: www.myCigna.com
CIGNA Provider Network The OAP network allows you to receive a higher benefit from the plan and reduce your out-of-pocket expenses for both medical and prescription drugs. Members can access high quality providers by looking for those with a "Tier 1" designation (when available).	**Provider Lookup** *Phone:* 1-800-244-6224 *Online:* www.myCigna.com or the myCigna app
SMIC (an Amwins company) Eligibility, billing, and premium collection are handled by SMIC. SMIC provides the enrollment portal for ongoing additions and terminations as well.	**SMIC Team** *Group email*: smic.tcnsupport@amwins.com *Phone*: 1-715-303-6115
CIGNA – Dental and Vision Coverage (optional) CIGNA is the insurance company contracted to handle the dental/vision benefits available under The Corps Network Health Plan. They process the claims and provide customer service. *Claims Addresses* Medical/Dental Claims The Corps Network Claims PO Box 182223 Chattanooga, TN 37422-7223 Vision Claims The Corps Network Claims PO Box 385018 Birmingham, AL 35238-5018	**Customer Service/Claim Forms** *Dental - Phone*: 1-800-244-6224 *Vision – Phone*: 1-877-478-7557 *Website*: www.myCigna.com
Via Benefits – Post service marketplace for individual health plans Free online resource where you can shop for and enroll in health insurance for after your service coverage ends.	**Customer Service** *Phone*: 1-800-591-2611 *Website*: marketplace.viabenefits.com