Corpsmember Health Plan — Medical, Prescription & AD&D

The CorpsNetwork
Strengthening America through service and conservation

September 1, 2020 to August 31, 2021
Medical by Cigna, AD&D by Gerber
Medical Group Number: 3338030

Cigna

Benefit / Provision	Cigna Open Access Plus Provider	Out-of-Network
Deductible Per Plan Year (September 1 – August 31) **(Applies to all services except in-network Preventive)**	$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%
Professional Services (Office, Surgery, Lab & X-Ray, Allergy Injections)	80%	50%
Telehealth (includes Behavioral Health)	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 and Outpatient)	80%	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	
Rate (Per Corpsmember, Per Month)	$363.98*	

Notes:

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

****100% of premium is paid by your program.***

This is a summary of your 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

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 2020 - 2021

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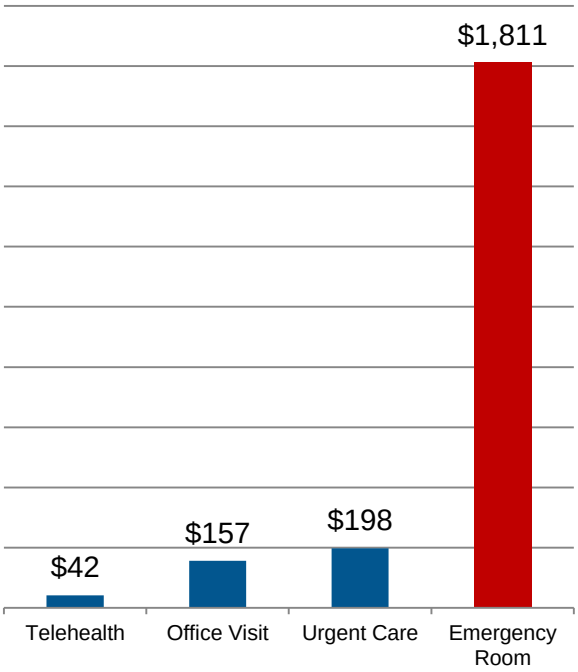
Cigna.

- ✓ **Read your Benefit Summary**
  - Know your benefits before you use them
- ✓ **Find your virtual ID card on the Cigna app**
- ✓ **Do the Scavenger Hunt on the Cigna app after you have your ID number and enter to win a prize!**
- ✓ **Locate a Cigna *Open Access Plus* Preferred Provider**
  - Click on "Find a Doctor" at myCigna
  - For high quality providers, look for the
- ✓ **Know your options for care when you need it – and choose the most appropriate**
  - Nurseline — Can help determine appropriate place to seek care
  - Telehealth — Convenient and inexpensive for 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
- ✓ **Pre-register for convenient Telehealth on myCigna.com**
  - Phone or chat doctor visits
  - Amwell or MDLIVE for medical, or both!
  - Behavioral health (under Specialty in the Behavioral Directory link)
- ✓ **Get your Preventive Care**
  - Routine care free with 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 2019
- Telehealth based on services received through Amwell or 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 one month of suspension. Premium must be paid by the program without interruption. Relation, 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. Corpsmembers are not considered employees and more aptly meet the definition of a volunteer. 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

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 Relation 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 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, Relation 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@willistowerswatson.com with questions.

Note About Plan Administration

Once your Program is set up for coverage at Relation, all adds, terminations and changes of corpsmember information will all be done by the Program Administrator on Relation's online enrollment portal. On the 13th of each month, you will receive an email alert from Relation Insurance Services that your invoice is ready to download.

Corpsmember Health Plan — Dental/Vision Plan 2

Plan Year: September 1, 2020 to August 31, 2021

Dental/Vision by Cigna
Group Number: 3338030

Dental Benefit	Cigna Dental Plan 2	
	Cigna DPPO Dentist	Out-of-Network
Deductible Per Plan Year (September 1 – August 31)	Applies to All Services $25	
Maximum Dental Benefit Per Plan Year (September 1 – August 31)	$1,000	
Diagnostic and preventive care (2 per Plan Year): Cleaning, Exam, Routine X-Rays	100%	
Basic Services: Fillings, Root Canals, Periodontics, Simple and Surgical Extraction, Stainless Steel Crowns	50%	50% of Usual & Customary

Vision Benefit	Cigna Vision Plan
Exam	Covered in full
Lenses / Contacts / Frames	$100 reimbursement per Plan Year

Plan 2 — Dental/Vision Rate	$25.94 per member per month

Important Information About Your Dental/Vision Plan

- **Customer Service** at Cigna is available to answer questions regarding benefits and claim status.
  ***Dental** Phone*: 1-800-244-6224 ***Vision** Phone*: 1-877-478-7557
- **Plan info**, including vision claim forms, contacts and claim status can be accessed at www.mycigna.com or on the Cigna app.
- **You will save money and stretch your dental benefit dollars** by using a Cigna DPPO Advantage or DPPO network provider when available.
- **Dental and Vision Provider look up** is available online or on the myCigna app.
- **Vision claims not billed by a Cigna Preferred Vision Provider are on a reimbursement basis and should be submitted to Cigna at:**

The Corps Network Claims
Cigna — Vision Claims
PO Box 385018
Birmingham, AL 35238-5018

Health Plan Contact List

Organization	Primary Contact
The Corps Network The Corps Network is a national membership organization that provides 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 program.	**Lashauntya Moore**, Member Services Coordinator *Phone:* 1-202-737-6272 ext. 104 *Email:* *lmoore*@corpsnetwork.org *Website:* www.corpsnetwork.org
Willis Towers Watson Willis Towers Watson, as the broker for The Corps Network, created the Health Plan in February of 1992. They provide ongoing management of the insurance program. Willis Towers Watson is also available for general questions and concerns from program administrators.	**Julie Nelson**, Associate Director *Phone:* 1- 206-812-7296 *Email:* julie.nelson@willistowerswatson.com
CIGNA – Group Number 3338030 Cigna administers the medical/prescription drug coverage. That includes claims processing and customer service, as well as generation of welcome packets and virtual ID cards.	**Customer Service (Medical/Prescription)** *Phone:* 1-800-244-6224 *Website:* www.cigna.com or: www.myCigna.com
CIGNA Open Access Plus (OAP) Preferred 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.	**Provider Lookup** *Phone:* 1-800-244-6224 *Online:* www.myCigna.com or the myCigna app
Relation Eligibility, billing, and premium collection are handled by Relation. Relation also handles any questions related to these functions. *Relation Insurance Services* *PO Box 25936* *Overland Park, KS 66225*	**Andrea Denning**, Account Coordinator *Email*: andrea.denning@relationinsurance.com *Phone:* 1-800-955-1991 ext. 7465 *Group email:* corps@relationinsurance.com *Fax:* 913-327-0201
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 Address* The Corps Network Claims CIGNA – Dental/Vision Claims PO Box 182223 Chattanooga, TN 37422-7223	**Customer Service/Claim Forms** *Dental - Phone*: 1-800-244-6224 *Vision – Phone*: 1-877-478-7557 *Website*: www.myCigna.com

Dental/Vision FAQs — Plan Administrator

What groups are eligible for the dental/vision plan?

The Corps Network member groups that are enrolled in the medical/prescription drug plan or groups that enroll in the medical/prescription drug plan concurrently with the dental/vision.

Can our group add dental/vision benefits to our existing medical/prescription drug plan at any time in the year?

Yes. Dental/vision can be added anytime during the year, but benefits will be based on a September – August plan year (deductible, benefit maximum, etc.), regardless of the effective date of your program or your members.

How does dental/vision member eligibility compare with the medical/prescription drug benefits?

It is designed to mirror the medical/prescription plan eligibility. This includes the definitions for eligible corpsmembers, exclusions for a covered member's dependents and a program's permanent staff. If your program provides coverage for part-time members or imposes a waiting period on new members, the same rules will apply to both the medical/prescription plan and dental/vision plans.

Can a member waive dental/vision coverage?

Not if they are enrolled in the medical plan. Both the medical and dental/vision plans will have common eligibility, meaning anyone enrolled in one plan must be enrolled in the other as well. No member can have medical/prescription only or dental/vision only.

How does continuation of coverage work with the dental/vision plan?

It works the same as the medical. COBRA is Employer/Employee legislation. Corpsmembers are not considered employees and more aptly meet the definition of a volunteer. Therefore, COBRA coverage will not be offered.

"Gap" coverage for up to 2 months between one service term and the next is offered for corpsmembers who sign up for a second term of service.

Who will administer the dental/vision benefits?

Cigna has been selected to insure the dental/vision program. Cigna will process claims, perform customer service and distribute coverage information. Since eligibility on the dental/vision plan must mirror medical enrollment, Relation Insurance Services will be the contact for any eligibility changes (additions, terminations) and will also handle monthly invoicing.

Will I have to make separate changes for medical and dental/vision enrollments?

Enrollment changes are made through Relation's online system and will apply to both medical and dental.

Dental/Vision FAQs — Plan Administrator

Who should I contact with administrative questions?

Eligibility and billing questions should be directed to Relation Insurance Services. All other questions regarding claims, benefits, network providers, etc. should be directed to Cigna. Inquiries prior to enrolling or for general issues, please call Willis Towers Watson.

Is there a list of contracted vision providers?

Yes. You will find Cigna contracted vision providers at myCigna.com. Services billed by non-contracted providers are filed by the member using a vision claim form found on myCigna.com.

What are the differences between Plan 1 and Plan 2?

Plan 1 is designed to maximize benefits when a program's members have network dentists available. Plan 2 is intended for programs that have members serving in areas where network dentists are not available.

What are the strengths/weaknesses of Plan 1?

Plan 1 is less expensive than plan 2 and, when services are received from network dentists, will still provide as much or more benefit than plan 2. Type II services such as fillings, oral surgery and root canals are covered at 70% in-network rather than 50%. If care is received from non-network dentists, payment drops to 50% for Type II and all benefits will only be considered up to the negotiated fee. This will often result in balance billing (see description below) and additional cost for the member.

What is balance billing?

Balance billing refers to amounts over the allowance that Cigna considers for payment on a particular procedure. Network providers, according to their contract with Cigna, are not allowed to bill a patient any amount of their normal charges that exceed the network negotiated fee. However, non-network dentists are under no such obligation. If their charges exceed those considered by Cigna for payment, they will bill the 'balance' remaining to the member.

What are the strengths/weaknesses of Plan 2?

Plan 2 is more expensive than Plan 1 but covers out-of-network services to the 90th percentile of the Usual and Customary (U&C) fee. This higher allowed amount on non-network claims will result in less balance billing. This is the only advantage that Plan 2 has over Plan 1.

Dental/Vision FAQs — Plan Administrator

What is Usual and Customary (U&C)?

The U&C allowance is determined by Cigna using prevailing charges in a particular geographical area. Plan members are reimbursed according to the appropriate charges in the dentist's ZIP code. The 90th percentile of U&C means that 90% of the dentists in a particular ZIP code charge at or below the plan allowance for a given procedure.

Which dental/vision plan should our group choose?

As a general guideline, if your members have access to providers in the Cigna DPPO network and a reasonable expectation they will use them, Plan 1 is the best choice. If you have a significant number of members that will not have access to network dentists or you suspect they will be using the services of non-network dentists, Plan 2 is worth considering to lessen the effect of balance billing.

How do I tell if there are Cigna DPPO network dental providers in my area?

Prior to placing the dental plan with Cigna, an analysis of enrollee locations showed that approximately 95% of members had at least two network dentists within 10 miles. The best way for a group to determine network availability is to check online. Go to http://hcpdirectory.cigna.com/web/public/providers and click on 'find a dentist'. Enter your search criteria to access a list of DPPO dentists.

Can we offer both plans and let members choose which one they prefer?

No. Only one plan can be offered per group. Vision benefits are included with both plans.

What if I have any other questions about adding dental/vision coverage or how the plan will work?

Email Julie Nelson at Willis Towers Watson at julie.nelson@willistowerswatson.com.