



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 the Willis Towers Watson team at WTW_TCNteam@willistowerswatson.com with any 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.