# AmeriCorps Health Care Plans I & II

## Administrative Manual

Plans Underwritten by *CONTINENTAL ASSURANCE COMPANY*

Plans Administered by *STRATEGIC RESOURCE COMPANY*

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# Introduction

Under the AmeriCorps program, you have received a grant in support of your efforts to "engage Americans of all ages and backgrounds in community-based national service." Health care coverage is a vital part of this program. The health care plan is underwritten by Continental Assurance Company, Chicago, Illinois. Administrative functions are handled by Strategic Resource Company (SRC), Columbia, South Carolina.

This administrative manual outlines the procedures for implementing the health care plan. Please take a few moments to review the manual and acquaint yourself with the process. If you have questions after reading the manual, please call SRC and ask to speak to an AmeriCorps Service Unit representative. They will be happy to help you.

**Please be aware that this manual is not a legal document. In the event of a discrepancy, the policies, and other legal documents will rule.**

# Start Up Information

## Program Data Form

Once new programs are identified, SRC sends them an Americorps Program Data Form, which is to be completed by the Program Representative. The Americorps Program Data Form is completed and returned to SRC with basic information that enables set-up of the grantee/subgrantee in SRC's information system.

## Program Number

During set-up, SRC assigns a Program Number to all reporting programs. Program numbers are five digits beginning with a 3 (for example, 30999). You should use your Program Number on all forms and correspondence, and when you call SRC with questions about the health care program.

## Program Materials

The receipt of a completed Americorps Program Data Form also prompts SRC to assemble and send a package of Program Materials to the appropriate agency. The program materials package consists of:

- An Administrative Manual – contains all the necessary materials to administer the Health Plan
- A supply of Brochures, ID Cards, and Plan Information Summaries for each person enrolled in the plan
- A Certificate of Insurance
- Claim Forms
- A supply of forms used in managing the plan (samples of these forms are included in the Forms Index of this manual).

During the start-up phase, each program should designate an administrator to serve as the contact person for the health care plan. SRC will contact the administrator to verify receipt of the materials, review the administrative process and answer any questions.

# Enrollment

## Who Is Eligible?

All **FULL-TIME AMERICORPS MEMBERS & PROMISE FELLOWS**, are eligible for coverage under the health care plan. A person is not eligible for the plan if they are covered by any other health care policy, as excessive coverage and duplication might result. Please note that dependents cannot be covered under the plan.

**PART-TIME MEMBERS** may also be enrolled in the health care plan. However, you may not use funds from the Corporation to pay for the premium cost. The exception to this regulation is for part-time members who are serving in a full-time capacity for a sustained period of time (such as summer or full time for 900 hours). The cost of the premium for part-time members is the same as for full-time members. Monthly premium for part-time members will be listed on the invoice with full-time members and payment for premium must be included. Separate payments or payment from the member will not be accepted.

A person who is not eligible for the plan must fill out a Waiver Form. The Waiver Form verifies that the person waivered coverage under the plan and eliminates possible confusion if the insured subsequently submits a claim. All waiver forms should be maintained in your program's files. An insured's waiver of coverage is reported to SRC on the AmeriCorps Health Care Roster Form, which is explained in more detail in the Monthly Reporting section of this manual.

## When does Coverage Begin?

Each eligible person's coverage is effective on the first day the person becomes active in the AmeriCorps program, provided the person enrolls and does not waive coverage.

## How do I Sign Up Those Who Need Health Care?

To enroll simply enter each active person on an AmeriCorps Health Care Roster Form. AmeriCorps Health Care Roster Forms are completed and sent to SRC. From the Roster, SRC enters enrollment information into its information system and establishes health coverage for that person.

Subsequent changes to enrollment are also reported on the AmeriCorps Health Care Roster Form. Details on how to complete rosters are discussed later in the Monthly Reporting section of this manual.

## How Do I Inform Those Enrolled About the Health Plan?

You should give each insured who is eligible for the plan the following materials:

- Brochure
- Plan Information Summary
- ID Card
- Questions and Answers
- Medical Claim Form
- Benefit Provisions
- Beneficiary Form for Plan II (the completed form is maintained in Program files)

The Plan Information Summary describes the health care plan. It contains specific details of the benefits covered (e.g., medical charges which are included and those which are excluded). Each covered person must receive a Plan Information Summary. While the brochure and this manual contain much information about the plan, nothing in the manual or brochure supercedes anything in the Plan Information Summary. In the case of discrepancies over information presented in the Plan Information Summary, the master policy language will govern.

# Monthly Reporting

## AmeriCorps Health Care Roster Form

The AmeriCorps Health Care Roster Form is used to report the people who will have health care coverage, as well as those who waive coverage or end coverage. After sending the initial AmeriCorps Health Care Roster Form, a new roster is sent to SRC by the 15$^{th}$ of each month even if you have no changes for health coverage from the previous month.

The purpose of reporting each month is to provide a positive record of either "no changes" or to notify SRC of any changes to the health care coverage status of your insured.

**Please follow these instructions for completing Monthly AmeriCorps Health Care Roster Forms:**

1. Always complete Part A.
   - In months where there are no status changes for anyone enrolled, or you do not have new enrollment, simply complete Part A and check the ☐ **NO CHANGES** box.

   [TIP: Use the AmeriCorps Health Care Roster Form in the pocket of your Administrative Manual to fill in the Program Number, Program Administrator, Program Name and Phone Number, and make several copies for your future use in order to save time.]

2. Complete Part B only when you have new enrollment, terminations, or other changes affecting existing coverage:
   - add **new insured** who you wish to be covered under this plan
   - show those who are **ineligible** because they are covered through another plan and they signed a waiver
   - include those who **dropped** coverage and signed a waiver
   - include those who **terminated** their active participation in the AmeriCorps program (be sure to provide current home address information for all terminations for Continuation of Coverage notification)
   - include those who **waive coverage** due to having other coverage
   - include those who have a **correction or a change** in their name, address, or Social Security Number

3. Provide all required information requested on the form and enter the corresponding action code and date action took place for each person you list in Part B.
   - Action Codes are:

| | | | |
|---|---|---|---|
| N = | New Enrollment For Americorps Member | NPT= | New Enrollment For Part-time |
| R = | Reinstatement For Coverage | C = | Name, Address, or Social Security Number Change |
| I = | Ineligible For Coverage | W = | Waiver of Coverage |
| D = | Dropped Coverage | NPF= | New Enrollment For Promise Fellows |
| T = | Terminates From The AmeriCorps Program or the Program Terminates (provide last known address) | | |

***FAX ROSTERS TO SRC***
***1-803-865-3787***
***ROSTERS MUST BE RECEIVED AT SRC***
***BY THE 15TH OF EACH MONTH***

## Enrollment and Invoices

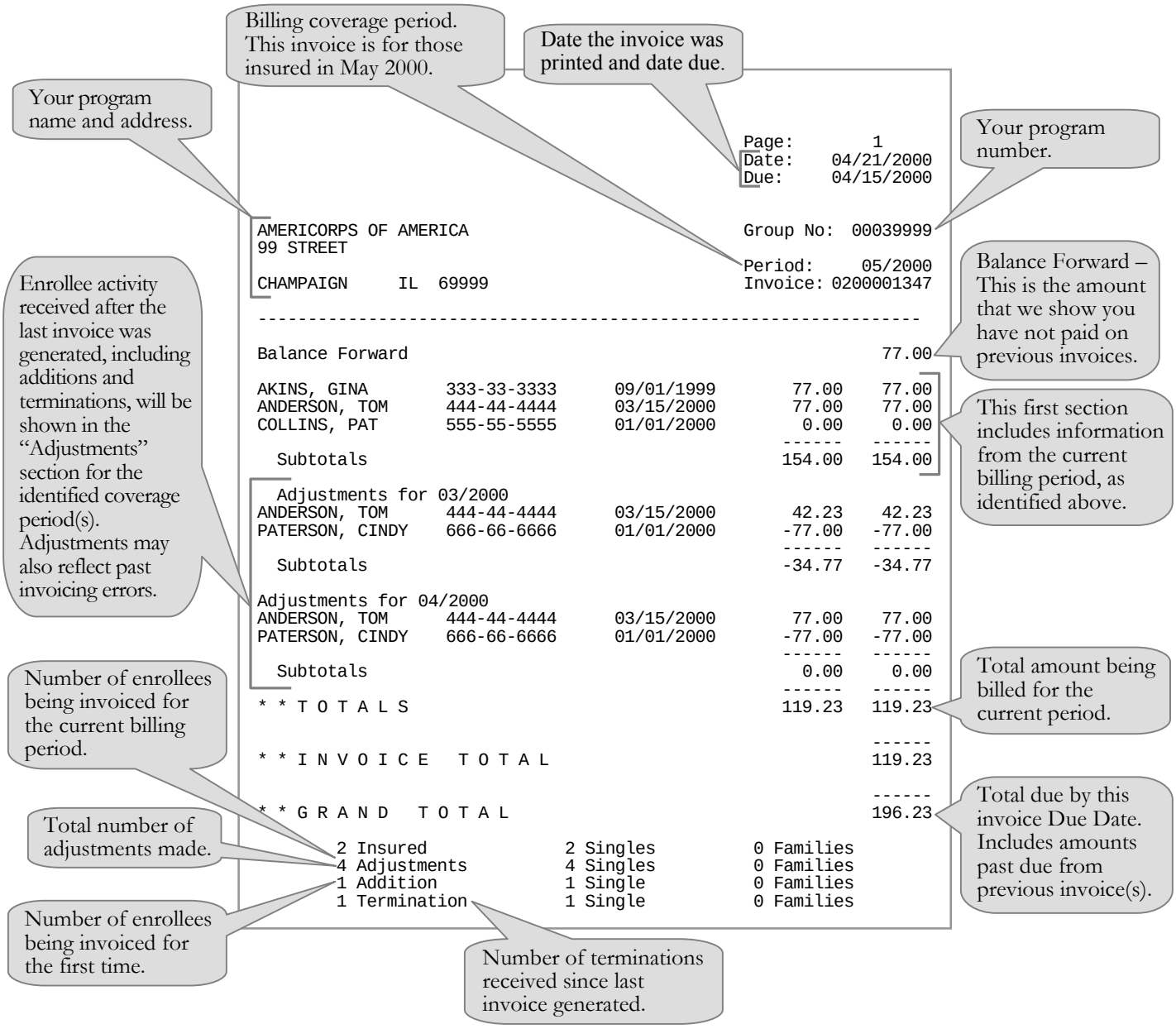
Upon receipt of completed AmeriCorps Health Care Roster Forms, SRC updates enrollment records to enable processing of claims and to begin the invoicing process. SRC enters all reported information into its enrollment and premium accounting system. This phase of the monthly invoice and enrollment cycle begins on the 16th of each month and takes about one week to complete.

Rosters received at SRC after the 15th are not entered until after invoices are generated. This means any "adjustments" (i.e., additions, terminations, or changes) not received on rosters by the 15th will not be reflected until the next invoice cycle.

Once all Rosters for the period are entered, a program invoice for coverage in the upcoming month is generated and mailed to your program. Invoices are sent to the location designated on the Americorps Program Data Form as the recipient of the invoices.

When submitting your monthly premium to SRC, be sure to indicate on the check stub your AmeriCorps assigned program number. Because AmeriCorps has many agencies with the same name, this will ensure that the premium payment is properly applied to your Program.

## How to Read Your Monthly Invoice




## Adjustments

Invoices for health care premium payments for AmeriCorps insured are applied to provide coverage "in advance." This means that invoices for a given month are based on rosters received by the 15th of the previous month (for example, the Program invoice for June is based on the roster received by May 15 and July's invoice is based on the roster received by June 15, and so on).

Applying enrollment and invoicing in advance may result in "adjustments" which must be made to invoices from time to time. Adjustments are required when a covered person is terminated, drops coverage or becomes ineligible for some other reason after the cut off for roster receipt at SRC on the 15th of the month. Adjustments required for rosters submitted after the 15th or changes occurring after the 15th will be reflected on future invoices. Adjustments and credits are only applied for two months back. Adjustments and credits should never be made from the monthly invoice. Adjustments and credits are applied only when indicated on the monthly roster.

## Prorations

Payments for the health care plan are prorated by SRC for those insured whose effective dates are after the first day of the month. In the first month of a person's enrollment, a daily calendar rate will be charged for those people who are not enrolled for the full calendar month. However, payment for the month in which a person leaves the program will not be prorated. A full monthly payment is required for all those insured in their last month. Invoices should not be prorated by the completing agency…prorated billings will be calculated by SRC only. If you have questions about prorated invoice amounts, call SRC's AmeriCorps Service Unit and they will be happy to answer your questions.

# Termination

## Termination Of Coverage

Health coverage under this plan ends when:

- An insured is reported to SRC on the AmeriCorps Health Care Roster Form under the Action Code column as terminated ("T")[1]
- The insured withdraws from the plan by completing a Waiver Form and is reported to SRC on the AmeriCorps Health Care Roster Form under the Action Code column as ineligible ("I");
- The health care plan terminates.

***Terminations will never be processed by striking the name on the invoice. You must always submit a roster for terminations and all other changes.***

## Reinstatements

Those who are reinstated must be reported on the AmeriCorps Health Care Roster Form in the Action Code column as an "R", show the date of reinstatement in the Action Date column.

## Extension of Benefits For Total Disability

Medical benefits may be extended for up to 90 days for a totally disabled person whose coverage terminates while that person is totally disabled. The Extension of Benefits, however, is permitted only for the injury or sickness which caused the total disability and only during the uninterrupted continuance of such disability.

The disabled person may be eligible to elect Continuation of Coverage. See the section entitled "Extension of Benefits" in the Certificate of Insurance for complete details.

## Continuation of Coverage

Terminated insureds who become ineligible for coverage under the plan may choose to continue their coverage by paying their own premiums. Once the termination date is reported via the Roster, SRC will mail a Continuation of Coverage Election Form to the person's last known home address. Therefore, be sure to complete the address portion of the AmeriCorps Health Care Roster Form whenever you report terminations.

[1] **A final roster terminating all insured must be submitted when your AmeriCorps project ends. If a new group of people are enrolled in an extension or a grant renewal, then a new AmeriCorps Health Care Roster Form must be sent to SRC to initiate the new coverage. Also, when your project is extended or renewed and new people are added, you must call, Fax, or mail a Request for Materials form to the AmeriCorps Service Unit at SRC to obtain new materials (i.e., brochures, Plan Information Summaries, ID cards, etc.).**

# Submitting Claims

## Claim Form

Those insured must complete and submit an AmeriCorps Medical Claim Form with every itemized bill.

## Medical Bills

Actual bills must be submitted. Copies of bills, canceled checks, and "balance due" bills are not acceptable.

Each bill must show:

- The full name of the patient;
- Diagnosis (ICD-9 code);
- The type and date of each service;
- A complete description of each service (not just "professional services");
- The amount charged for each service. A doctor's bill must show the diagnosis (nature of illness), not just "office visit";
- Prescription bills must include the name of the drug or the prescription number, and the condition being treated by the medication.

## Dental Claims

How to file dental claims: A sample claim form for dental coverage will be provided to the insured. Those insured should make a photocopy of the sample form for use whenever he/she makes a claim for services rendered or a pre-treatment estimate. They should send the completed form to: CLAIMS, PO Box 23759, Columbia, SC 29224-3759. The insured may request claim forms by writing to this address. The dental provider may prefer to file the claim using his or her own form. But if an insured has a claim, they must send in a signed claim form of the type contained in this booklet. This will help ensure prompt processing of the claim. A completed claim form must be submitted within one year of the date of the loss. For Claims Customer Service call 1-800-788-6557, Monday through Friday, 8:30 a.m. to 4:00 p.m. ET.

***ALL CLAIMS SHOULD BE SUBMITTED TO:***

AmeriCorps Claims
c/o SRC
PO Box 23907
Columbia SC 29224-3907

# Customer Assistance

## For Insured — 1-800-788-6557

When questions arise regarding plan benefits or coverage issues, the insured or programs may call the SRC Customer Service Center for assistance. For quicker handling, please have the insured's social security number available and the program name and number. Customer Service Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time to answer plan benefit inquiries and Monday through Friday, 8:30 a.m. to 4:00 p.m. Eastern Time to answer questions regarding the status of a specific claim.

## For Programs — 1-803-865-3737

For administrative questions, programs may call SRC's AmeriCorps Agency Service Unit. SRC's Unit Staff will be happy to assist you with any questions or concerns you may have. Please have your program number available so that your program's record can be accessed quickly. SRC's AmeriCorps Agency Service Staff is available Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Time.

# Forms

To order forms, complete the Request for Supplies Form [Form # RSF (07/2003)]. Include the name of the form, the form number (usually located in the lower right-hand corner of the form), and the quantity you need. Always include your program's full name, your program number, and your street address (not box number) on the order form.

## Forms Index

*For Plan I you will need the following forms:*

| Form Name | Number |
|---|---|
| Medical Claim Form | MCF (07/2003) |
| Brochure (CNA Option I Summary) | BI (07/2003) |
| AmeriCorps Health Care Roster Form | HCRF (10/2002) |
| Plan Information Summary | PIS-I (07/2003) |
| Request for Supplies | RSF (07/2003) |
| AmeriCorps CNA Option I Overview | OVI (07/2003) |
| Waiver Form | WF (07/2003) |

*For Plan II you will need the following forms:*

| Form Name | Number |
|---|---|
| Medical Claim Form | MCF (07/2003) |
| Dental Claim Form | DCF (07/2003) |
| Dental Coverage Information Option II | DCINFO (07/2003) |
| Brochure (CNA Option II Summary) | B2 (07/2003) |
| AmeriCorps Health Care Roster Form | HCRF (10/2002) |
| Plan Information Summary | PIS-II (07/2003) |
| Request for Supplies | RSF (07/2003) |
| AmeriCorps CNA Option II Overview | OVII (07/2003) |
| Waiver Form | WF (07/2003) |
| Accidental Death Insurance Proof of Loss Form | ADPLF (07/2003) |
| Beneficiary Designation and Change Form | BDF (07/2003) |

Please make sufficient copies of all forms for future use and maintain an original copy in your Administrative Manual.

**Please Note: Submitting a completed Roster Form will not automatically generate Plan Information Summaries and ID Cards for the new insured. You must submit a completed Request for Supplies Form for the appropriate quantities of these items.**

# Request for Supplies Form

Health Care Plan for AmeriCorps

Please show exact Form #'s located in your Administrative Manual. Please complete the bottom portion of this form, indicating street address, and fax the entire form to (803) 865-3787.

**STRATEGIC RESOURCE COMPANY**
P.O. Box 23907
Columbia, SC 29224-3907
Phone: 803-865-3737
Fax: 803-865-3787

| Program # | Program's Name | Date |
|---|---|---|
| | | |
| **Form Number** | **Description of Materials** | **Quantity Requested** |
| | | |
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## SRC SHIPPING OFFICE USE ONLY

Date: _____

HOW: UPS: G 2 P US 1st FedX S P

BY: _____ Tracking #: _____

**From:**
SRC/AmeriCorps
PO Box 23907
Columbia, SC 29224-3907
803-865-3737

**To:**
Program's Name: _____
Program Director's Name: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____

# Health Care Plan For AmeriCorps

## Waiver Form

Name: _____

Social Security Number: _____

Date of Birth: _____

Date of Hire: _____

Phone Number: _____

I hereby certify that I am otherwise covered by a health care plan and therefore am not eligible to participate in the Health Care Plan provided by AmeriCorps. My signature below, acknowledges that I waive coverage under this Plan.

Signature: _____ Date: _____



# Health Care Plan For AmeriCorps

## Waiver Form

Name: _____

Social Security Number: _____

Date of Birth: _____

Date of Hire: _____

Phone Number: _____

I hereby certify that I am otherwise covered by a health care plan and therefore am not eligible to participate in the Health Care Plan provided by AmeriCorps. My signature below, acknowledges that I waive coverage under this Plan.

Signature: _____ Date: _____

AmeriCorps Waiver Form Form # WF (07/2003)

# AMERICORPS HEALTH CARE ROSTER FORM

Page _____ of _____

**Please complete this form and fax to SRC at (803) 865-3787 by the 15th of each month**
(late or incomplete reports may require adjustments on future invoices).

PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION

## PART A—PROGRAM INFORMATION

| Program Number 0 0 0 ☐☐☐☐☐ | Program Name | ☐ No Changes |
|---|---|---|
| Program Administrator | Report Completion Date MM DD YY ☐☐/☐☐/☐☐ | |
| Signature | Phone Number (☐☐☐)☐☐☐-☐☐☐☐ | |

## PART B—INSTRUCTIONS

1. Complete an *AmeriCorps Health Care Roster Form* each month, to include new enrollments, ineligibles, changes, terminations, and Changes of address.
   a. Include in Part D, all new enrollment ***and*** any changes in previously reported data since your last report.
   b. For each insured listed in Part D, please be sure to complete all columns and enter the appropriate Code. ➡
   c. The last known home address must be included for all terminations, so that SRC can send a Continuation of Coverage Election Form.
2. *Even if there is no activity to report, you must submit a completed Roster Form each month.* For months with no activity, simply complete Part A and check "No Changes."
3. **Fax completed Roster Form to (803) 865-3787.**
4. Rosters must be received at SRC by the 15th of each month. Information reported on Rosters received after the 15th will be processed the following month.
5. Credits or adjustments that have occurred during the past two months will be applied.

**ACTION CODES**

| | | |
|---|---|---|
| N | = | New Enrollment for AmeriCorps Members |
| NPF | = | New Enrollment for Promise Fellows |
| NPT | = | New Enrollment for Part-Time Members |
| R | = | Reinstatement of Coverage |
| I | = | Ineligible Member |
| D | = | Drop Coverage For Insured |
| T | = | Terminated (give last known home address) |
| C | = | Name, Address, or SS# Change |
| W | = | Waived Coverage |

## PART C—PROGRAM END INFORMATION

Check here ☐ if program has ended. Enter End Date MM DD ☐☐/☐☐ Reason: ☐ Funding Ended ☐ No Full-Time Enrollment ☐ Changed Carriers

Will your program return? Yes ☐ No ☐ Date of Return MM DD ☐☐/☐☐ Projected number of enrollment

## PART D—ENROLLMENT INFORMATION

| Social Security Number | First Name | Last Name | Sex | DOB | Hire Date | Action Code | Action Date (MM/DD/YY) | Street Address | City, State, Zip Code |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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# AMERICORPS HEALTH CARE PLAN
# CHANGE FORM

You should use this form if you want to change your Program's existing coverage from CNA Option I to CNA Option II or from CNA Option II to CNA Option I.

*Once you have completed and signed the Change Form, fax it to (803) 865-3787.*

**Change Coverage From CNA Option I to CNA Option II** ☐ **Yes** ☐ **No**

**Change Coverage From CNA Option II to CNA Option I** ☐ **Yes** ☐ **No**

PLEASE PRINT LEGIBLY OR TYPE ALL REQUIRED INFORMATION

**PART A—PROGRAM INFORMATION**

| | |
|---|---|
| Program Number 0 0 0 ☐☐☐☐☐ | Program Name |
| Address | |
| City, State, Zip Code | |
| Phone Number (☐☐☐) ☐☐☐ - ☐☐☐☐ | Fax Number (☐☐☐) ☐☐☐ - ☐☐☐☐ |
| Change Authorized By: Name (please print) | |
| Title | Phone Number (☐☐☐) ☐☐☐ - ☐☐☐☐ |

**Group affiliated with:** ☐ **State** / ☐ **National** / ☐ **Tribes & Territories** / ☐ **Learn-n-Serve** / ☐ **Other**

**PART B—AUTHORIZATION TO CHANGE COVERAGE**

| | |
|---|---|
| Effective Date of Change MM DD YY ☐☐ / ☐☐ / ☐☐ | Projected Enrollment |

I authorize SRC to change the above-mentioned AmeriCorps Program from CNA Option I to CNA Option II. I fully understand that the monthly premium will increase per insured to CNA Option II rates.

| Signature | Title | Date |
|---|---|---|
| | | |

I authorize SRC to change the above-mentioned AmeriCorps Program from CNA Option II to CNA Option I. I fully understand that the monthly premium will decrease per insured to CNA Option I rates.

| Signature | Title | Date |
|---|---|---|
| | | |


**STRATEGIC RESOURCE COMPANY**
P.O. Box 23907
Columbia, SC 29224-3907
Fax: 803-865-3787


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**SRC/AMERICORPS OFFICE USE ONLY**

AmeriCorps Dept. Set-up Date:_____

Systems Set-up:_____ Method Informed: _____ Verifax:_____

Comments:_____

_____

**Continental Assurance Company**
**Continental Casualty Company**
**CNA Group Life Assurance Company**

# PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE ALSO APPLIES TO YOUR NON-MEDICAL INFORMATON. PLEASE REVIEW THIS NOTICE CAREFULLY.**

While the nature of insurance requires that we gather personal information about you, we know that this information must be protected. As required by law, we maintain the confidentiality of your information. The law also requires us to notify you of our legal duties and privacy practices. This Notice applies only to your personal information gathered in connection with a medical insurance product underwritten by one of the above named CNA companies. The terms in this Notice are effective April 14, 2003.

This Notice explains what personal information regarding you is **collected**, from whom it is collected, and how we may **use** and **disclose** your information for routine business purposes or as permitted by law in special circumstances. Any use or disclosure not listed here or permitted by law will only be made with your written authorization, which you are free to later revoke. We will not disclose information about our former customers except as permitted by law. This notice also advises of your rights regarding your personal information, and how you may contact us for additional information.

## WE MAY COLLECT YOUR PERSONAL INFORMATION

In order to service your policy and to process transactions that you request, we may collect information from several sources. We may collect information:

- **Directly from you** such as information you provide on your application for insurance or related forms;
- **About your transactions with us** such as your insurance premium, policy number, or payment history; and
- **From third parties** such as your employer, other affiliated CNA companies or other insurers, consumer reporting agencies and your health care providers. When required by law, we will first obtain your authorization before we seek information from third parties.

The personal information we collect may relate to your finances, employment, health, avocations, or other personal characteristics, as well as publicly available information about you. We may ask an insurance support organization, like a consumer reporting agency, to provide information regarding you that they have independently gathered. The insurance support organization may retain or disclose such information to others.

## WE PROTECT THE SECURITY OF YOUR PERSONAL INFORMATION

- Our employees are trained and required to maintain our privacy policies and procedures. Employees who violate these policies and procedures are subject to disciplinary action.
- We maintain physical, electronic and procedural safeguards to protect the security of your information.
- We require all third parties to whom we disclose information to maintain adequate security standards.
- We also take steps to protect against unauthorized disclosure of your personal information.

**Changes in our Notice.** We are required by law to abide by the terms of our current Notice. The terms of this notice apply to all records containing your information collected in connection with medical insurance products that are created or maintained by us. We reserve the right to change the terms of our

notice of privacy practices. Any change to the notice will apply to all personal information we maintain. You may ask for a copy of our current notice at any time. If we make any material changes to our notice, we will provide you with a revised notice.

As a general rule, we will not release your information except to you or someone that you designate in writing as your personal representative. However, there may be some instances, as discussed later in this notice, where release is otherwise required or permitted by law.

**WE MAY USE OR DISCLOSE YOUR PERSONAL INFORMATION FOR ROUTINE BUSINESS PURPOSES**

As permitted by law, we may use or disclose your personal information to service your policy and for other routine business purposes, including:

- **Normal business operations** such as underwriting your application, servicing your policy, or evaluating your claim;
- **Payment** purposes such as reimbursing your health care provider for covered services, processing your premium payments, or paying your claim; and
- **Treatment** purposes such as assisting your health care provider in treating you.

If you participate in a group plan, we may disclose your personal information to plan sponsors as necessary to administer your plan.
We may use or disclose your personal information, excluding medical records, to tell you about other health-related benefits or services that we offer or about health-related benefits or services that are available to our medical insurance customers.

**Recipients of the information** disclosed for the purposes described above may include affiliated and non-affiliated companies. Affiliated companies are within the CNA family of companies and include insurance companies, insurance agencies and service providers. Non-affiliated companies are outside the CNA family of companies and may include third party administrators (TPA's), service providers and insurance agencies. Service providers help us perform our activities. For example, they may include agents who service your policies, our affiliates, or billing companies. They also include third party administrators (TPA's), vendors that collect health or financial information, consumer reporting agencies, or other third parties that may assist us to fulfill your requests or provide you with products and services.

We will not disclose medical records, information relating to drug or alcohol abuse, mental health, or genetic or HIV testing without first obtaining your authorization, unless required by law.

**WE MAY USE OR DISCLOSE YOUR PERSONAL INFORMATION UNDER SPECIAL CIRCUMSTANCES**

If necessary, we may use or disclose your information for the following purposes:

- **As Required by Law.** We may disclose your information when required by law.

- **Public Health Activities.** We may disclose your information to public health authorities and other persons that are authorized by law to collect information for public health purposes. We may also disclose information if necessary to notify you or others of a potential exposure to a communicable disease.

- **Family/Friends Involved In Your Care.** In the event you are incapacitated, we may disclose your information to a family member, friend or legal representative who is assisting in your care or payment for your care. Such information will be limited to the minimum level necessary to assist in your care or payment for your care.

- **Health Oversight Activities.** We may disclose your information to a government health oversight agency for its investigations, audits, or other activities necessary to monitor government programs, the health care system in general, or compliance with civil rights laws.

- **Judicial Proceedings.** We may also disclose your information in response to a discovery request, subpoena, or other lawful process in connection with a lawsuit, but only if we have satisfactory assurance that reasonable steps have been taken to notify you or protect the confidentiality of your information.

- **Law Enforcement.** We may disclose your information to a law enforcement official in response to a warrant, court order, administrative order, or as otherwise may be required by law.

- **Serious Threats to Health or Safety.** We may disclose your information to an appropriate authority if necessary to reduce or prevent a serious threat to the health and safety of you, another person, or the public.

- **National Security.** We may disclose your information to federal officials for military and national security activities authorized by law.

- **Workers' Compensation.** We may disclose your information as authorized by and to the extent necessary to comply with the laws relating to workers' compensation and similar programs that provide benefits for work-related injuries.

- **Reporting Abuse or Domestic Violence.** We may disclose your information as required by law to report suspected abuse or domestic violence.

- **Coroners and Funeral Directors.** We may disclose your information as necessary to assist in the activities of a coroner or funeral director. We do not routinely release this information to Funeral Directors.

- **Organ donations.** We may disclose your information to organ banks and other entities as necessary to facilitate organ donations and transplants. We do not routinely release this information for this purpose.

- **Research.** We may disclose your information for research purposes, but only consistent with the regulations which govern such disclosures. These regulations do not allow research organizations to publish their results in a way where individuals could be identified.

## YOUR RIGHTS REGARDING YOUR PERSONAL INFORMATION

The following describes your rights regarding certain personal information that we maintain.

- **Confidential Communication with You.** If you believe that the disclosure of all or part of your information could endanger your safety, you may make a written request to receive communications from us by alternative means or at an alternative location.

- **Restriction on Use or Disclosure.** You may make a written request to restrict our use or disclosure of your information for our routine business practices or to persons involved in your care or the payment for your care, such as family members or friends. Please note that we are not required to agree to your request, if uses and disclosures of your information are necessary to perform our routine business activities.

- **Inspection and Copies of Information.** You may request, in writing, to inspect and obtain a copy of certain information related to enrollment, payment, claims, or records used to make decisions about you. We may charge a fee to cover costs we incur. As permitted by law, we may deny your request to inspect and copy in certain situations; for example, if we determine through a medical professional that access to the information would result in harm to you or others. If we deny access you may ask for a review of our denial.

- **Amendment of Information.** If you believe that information we hold is incorrect or incomplete, you may request, in writing, that your information be amended. Your request must include reason(s) that support making an amendment. As permitted by law, we may deny your request in certain instances. For example, we may choose not to amend your information if it was not created by us or if we do not have reasonable basis to make the amendment.

- **Accounting of Disclosures.** You may request, in writing, an accounting of certain disclosures made after April 14, 2003 including those related to Disclosures Required by Law, Public Health Activities, Health Oversight Activities, Judicial Proceedings, Law Enforcement, Serious Threats to Health or Safety, Workers' Compensation, Reporting Abuse, Domestic Violence, Coroners or Funeral Directors, Organ Donations, or Research as described above, or other similar non-routine disclosures.

**For Montana Residents**: Upon written request, you are entitled to receive record of any Company disclosures of your medical information that is maintained and accessible, and was made within 3 years prior to your request.

**HOW YOU MAY CONTACT US:**

If you wish to:

- obtain further information regarding our privacy policies;
- make a written request to exercise your rights as described above; or
- receive a copy of our current Privacy Notice,

Please make your request to:

Strategic Resource Company
Attn: HIPAA Compliance Department
P.O. Box 23759
Columbia, SC 29224
Phone 1-800-800-8121

**You may file a complaint** with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing of a complaint. To file a complaint with us, please contact:

CNA Consumer Services
333 S. Wabash
Chicago, IL 60604
Phone 1-888-679-9253

# AmeriCorps CNA Options I and II – Overview*

## General Information

- No pre-certification/approval is required.
- Per cause benefits are payable once for each accident or illness.
- Expenses must be incurred within 52 weeks of the first covered claim for any one occurrence or cause.

| Plan Benefits | Plan I | Plan II |
|---|---|---|
| Plan Year Deductible | $100 | $100 |
| Eligible Expenses Coinsurance Maximum | $4,500 | $4,500 |
| Percentage paid by plan before Coinsurance Maximum is satisfied [2] | 80% | 80% |
| Individual Out-of-Pocket Maximum (includes deductible) | $1,000 | $1,000 |
| Percentage paid by plan after Coinsurance Maximum is satisfied [2] | 100% | 100% |
| Per Cause Maximum Benefit | $50,000 | $50,000 |
| Pre-existing Conditions Maximum Benefit (does not apply to pregnancy) [5] | $1,000 | $5,000 |
| Prescription Drugs | 50% | Covered [1] |
| Mental & Nervous Disorders | Covered | Covered |
| Elective Termination of Pregnancy | Covered | Covered |
| Chiropractic Services | Covered | Covered |
| Preventative Exam Benefit | | |
| Maximum Benefit [1] | None | $150 |
| **Dental Benefits** | None | Covered |

| Benefit Limits | Plan I | Plan II |
|---|---|---|
| Hospital Benefits | | |
| Daily Room & Board Maximum [6] | $600 | $600 |
| Daily Intensive Care Facility Maximum [6] | $1,200 | $1,200 |
| Hospital Services other than Room and Board (in- or outpatient) | $2,000 | $2,000 |
| Substance Abuse Treatment [3] | | |
| Outpatient, Maximum number of visits allowed | 60 | 60 |
| Maximum per visit Benefit | $35 | $35 |
| Inpatient Maximum [4] | $10,000 | $10,000 |
| Maximum Benefit for Injury due to Motor Vehicle Accident | $10,000 | $10,000 |
| Maximum Benefit for Injury due to Organized Sports Injury | $5,000 | $5,000 |
| Specified Therapies (including acupuncture and physical therapy) | | |
| Outpatient Maximum Benefit [7] | $1,000 | $1,000 |
| Inpatient Maximum Benefit | $10,000 | $10,000 |
| Injury to Sound Natural Teeth, Maximum Benefit per Tooth | $250 | $250 |
| Emergency Professional Ambulance Service Maximum Benefit | $250 | $250 |

| Accidental Death Benefit | Plan I | Plan II |
|---|---|---|
| Maximum Benefit | None | $10,000 |

| Monthly Premiums | Plan I | Plan II |
|---|---|---|
| Standard Cost | $101.00 | $124.00 |
| Continuation of Coverage | $103.02 | $126.48 |

***Full Details Will Be Provided In The Plan Information Summary After Enrollment.***

1. Subject to coinsurance.
2. Where benefit is expressed as a percentage, usual & customary (U&C) fee levels will be the basis of payment.
3. Maximum of one occurrence for in- and/or out-patient.
4. Per plan year.
5. Benefits for pre-existing conditions are limited to the amount shown when incurred during the first 12 months of coverage. Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan.
6. Plan will pay the maximum or actual Hospital Charges, whichever is less (room & board based on semi-private room).
7. Covered only if immediately following covered surgery or hospital confinement.

# *Exclusions & Limitations – CNA Options I & II*

*No coverage is provided for loss caused by or resulting from:*

- work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- acts of war (declared or undeclared);
- expenses which are not approved by a physician;
- cosmetic surgery. This does not apply to:
  (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
  (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or
  (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
- eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses;
- glasses, hearing aids, or contact lenses except contact lenses when required because of surgery;
- services by an immediate family member or person living with the person requiring treatment;
- any period of custodial care confinement in a hospital or skilled nursing facility;
- service in the Armed Forces of any country; riot; or civil commotion;
- your operating, riding in, or descending from any aircraft, other than while a fare-paying passenger on a licensed, commercial, non-military aircraft;
- expenses for home health care services, unless provided in lieu of a hospital confinement;
- your commission of a felony;
- suicide or attempted suicide or any intentionally self-inflicted injuries, while sane or insane;
- dental care and treatment, except that required by injury and rendered within 90 days of the injury;
- treatment which is determined to be experimental or investigational;
- injury sustained while you are:
  (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or
  (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician;
- treatment of deviated nasal septum, including submucous resection and/or surgical correction;
- expenses in connection with an organ transplant;
- expenses for routine physical exams (unless required by law) (this applies to CNA Option I only); and
- any expense incurred after the date the policy terminates.

The Following Exclusions & Limitations are Applicable to the Accidental Death Benefit & the Dental Plan for CNA Option II Only:

*What is not covered under the Accidental Death Benefit:*

- death resulting from sickness of any kind;
- death which occurs more than 12 months from the originating accident; and
- death due to: use of alcohol, intoxicants or drugs; self-inflicted injury or suicide; war, service in the Armed Forces; riot, civil commotion or terrorism; or flying (unless as a fare-paying passenger on a regularly scheduled airline or on Military Airlift Command).

*What is not covered under the Dental Plan:*

- procedures begun before the insured became covered;
- any procedure begun after coverage ends.
- treatment that is unnecessary, experimental, or does not offer a favorable prognosis;
- expenses covered under another group plan or coverage required by law;
- expenses which the participant is not legally obligated to pay;
- elective or cosmetic treatment;
- correction of congenital malformations;
- procedures involving vertical dimension, correction of attrition or abrasion, occlusion, splinting, or bite analysis;
- services in any way related to TMJ or myofascial pain;
- orthognathic surgery;
- orthodontic treatment;
- prescribed drugs, analgesics, or anesthetics;
- instruction for diet, plaque control, and oral hygiene;
- charges for implants or their removal and other customized services or attachments;
- treatment of malignancies, cysts, and neoplasms; and
- charges for forms or missed appointments.

*Pre-Existing Conditions*

A "Pre-existing Condition" means any condition during the 6 months prior to and including the participant's effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment.

Benefits are limited to a maximum of $1,000 (for Option I) and $5,000 (for Option II) for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition. Coverage for pre-existing conditions will be provided once the participant has been covered under the plan for 12 consecutive months, subject to the limitations of the plan.

Every effort has been made to ensure the accuracy of this benefit plan brochure. The exclusions and limitations described above apply to the residents of most states, however state laws do vary. The laws of the participant's state may affect this benefit plan, but these differences in laws generally do not reduce the benefits. This brochure is not a legal document. In the event of a discrepancy, the policy would be the determining factor.

# AmeriCorps CNA Option I – Overview*

## General Information

- No pre-certification/approval is required.
- Per cause benefits are payable once for each accident or illness.
- Expenses must be incurred within 52 weeks of the first covered claim for any one occurrence or cause.

## Plan Benefits

| | |
|---|---|
| Plan Year Deductible | $100 |
| Eligible Expenses Coinsurance Maximum | $4,500 |
| Percentage paid by plan before Coinsurance Maximum is satisfied [1] | 80% |
| Individual Out-of-Pocket Maximum (includes deductible) | $1,000 |
| Percentage paid by plan after Coinsurance Maximum is satisfied [1] | 100% |
| Per Cause Maximum Benefit | $50,000 |
| Pre-existing Conditions Maximum Benefit (does not apply to pregnancy) [4] | $1,000 |
| Prescription Drugs | 50% |
| Mental & Nervous Disorders | Covered |
| Elective Termination of Pregnancy | Covered |
| Chiropractic Services | Covered |

## Benefit Limits

| | |
|---|---|
| Hospital Benefits | |
| Daily Room & Board Maximum [5] | $600 |
| Daily Intensive Care Facility Maximum [5] | $1,200 |
| Hospital Services other than Room and Board (in- or outpatient) [3] | $2,000 |
| Substance Abuse Treatment [2] | |
| Outpatient, Maximum number of visits allowed | 60 |
| Maximum per visit Benefit | $35 |
| Inpatient Maximum [3] | $10,000 |
| Maximum Benefit for Injury due to Motor Vehicle Accident | $10,000 |
| Maximum Benefit for Injury due to Organized Sports Injury | $5,000 |
| Specified Therapies (including acupuncture and physical therapy) | |
| Outpatient Maximum Benefit [6] | $1,000 |
| Inpatient Maximum Benefit | $10,000 |
| Injury to Sound Natural Teeth, Maximum Benefit per Tooth | $250 |
| Emergency Professional Ambulance Service Maximum Benefit | $250 |

## Monthly Premiums

| | |
|---|---|
| Standard Cost | $101.00 |
| Continuation of Coverage | $103.02 |

***Full Details Will Be Provided In The Plan Information Summary After Enrollment.***

1. Where benefit is expressed as a percentage, usual & customary (U&C) fee levels will be the basis of payment.
2. Maximum of one occurrence for in- and/or out-patient.
3. Per Plan Year.
4. Benefits for pre-existing conditions are limited to the amount shown when incurred during the first 12 months of coverage. Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan.
5. Plan will pay the maximum or actual Hospital Charges, whichever is less (room & board based on semi-private room).
6. Covered only if immediately following covered surgery or hospital confinement.

# *Exclusions & Limitations – CNA Option I*

*No coverage is provided for loss caused by or resulting from:*

- work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- acts of war (declared or undeclared);
- expenses which are not approved by a physician;
- cosmetic surgery. This does not apply to:
  (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
  (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or
  (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
- eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses;
- glasses, hearing aids, or contact lenses except contact lenses when required because of surgery;
- services by an immediate family member or person living with the person requiring treatment;
- any period of custodial care confinement in a hospital or skilled nursing facility;
- service in the Armed Forces of any country; riot; or civil commotion;
- your operating, riding in, or descending from any aircraft, other than while a fare-paying passenger on a licensed, commercial, non-military aircraft;
- expenses for home health care services, unless provided in lieu of a hospital confinement;
- your commission of a felony;
- suicide or attempted suicide or any intentionally self-inflicted injuries, while sane or insane;
- dental care and treatment, except that required by injury and rendered within 90 days of the injury;
- treatment which is determined to be experimental or investigational;
- injury sustained while you are:
  (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or
  (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician;
- treatment of deviated nasal septum, including submucous resection and/or surgical correction;
- expenses in connection with an organ transplant;
- expenses for routine physical exams (unless required by law); and
- any expense incurred after the date the policy terminates.

## *Pre-Existing Conditions*

A "Pre-existing Condition" means any condition during the 6 months prior to and including the participant's effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment.

Benefits are limited to a maximum of $1,000 for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition. Coverage for pre-existing conditions will be provided once the participant has been covered under the plan for 12 consecutive months, subject to the limitations of the plan.

Every effort has been made to ensure the accuracy of this benefit plan brochure. The exclusions and limitations described above apply to the residents of most states, however state laws do vary. The laws of the participant's state may affect this benefit plan, but these differences in laws generally do not reduce the benefits. This brochure is not a legal document. In the event of a discrepancy, the policy would be the determining factor.

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina;
SRC Insurance Services, Inc.; SRC Services, Inc.

# AmeriCorps
# CNA Option I Summary

## Medical Coverage

**A Limited Benefit Accident and Sickness Medical Plan.**

- Use any doctor or hospital you want.
- Covers non-work related expenses.
- ***Inpatient and Outpatient Benefits:*** After satisfaction of a $100 deductible each coverage year, the policy will pay 80% of the usual & customary charges incurred for covered medical expenses up to a coverage year maximum of $3,600. Once the coverage year maximum has been exhausted, the policy will pay 100% of the usual & customary charges incurred for covered medical expenses up to a total lifetime maximum benefit of $50,000 for each separate accident and sickness. Benefits will be paid, subject to any applicable limitation, for covered medical expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Charges must be incurred within 52 weeks from the date of the first covered loss for each separate Accident or Sickness and while the Covered Person's coverage is in force. No benefit will be paid for a charge that is incurred in connection with a particular Accident or Sickness if it is incurred more than one year after the date of the first covered loss for that Accident or Sickness.
- ***Covered Medical Expenses***:
  - Fees for diagnosis and treatment by a doctor, surgeon, registered nurse, professional anesthetist, or radiologist;
  - Hospital charges;
  - Laboratory, diagnostic, and x-ray examinations;
  - Rental charges for durable medical equipment, or the purchase of this equipment, whichever is less;
  - Emergency professional ambulance service to the nearest hospital; and
  - Prescription drugs (at 50%).
- ***Limited Medical Expenses:*** Certain covered expenses are limited to a scheduled amount or maximum benefit. A complete listing of these is available in the Plan Information Summary. These limitations involve covered charges for hospital room and board; motor vehicle accidents; certain sports accidents; expenses for ambulances; acupuncture; physical therapy; diagnosis and treatment of certain skin disorders; and treatment of alcohol and drug abuse disorders.
- ***Pre-existing Conditions:*** Benefits are limited to a maximum of $1,000 for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition (does not include pregnancy). Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan. This time requirement may be reduced by any creditable coverage the participant may have had.

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Este folleto contiene un resumen en inglés del Plan de AmeriCorps. Si usted tiene dificultad en entender cualquier parte de este folleto llame al número gratuito 1-800-788-6557. Nuestros representantes de consulta están disponibles de 8:00 a.m. a 8:00 p.m., de lunes a viernes (hora del Este) para darle asistencia en español.

# *Exclusions & Limitations – CNA Option I*

***No coverage is provided for loss caused by or resulting from:***

- work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- acts of war (declared or undeclared);
- expenses which are not approved by a physician;
- cosmetic surgery. This does not apply to:
  (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
  (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or
  (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
- eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses;
- glasses, hearing aids, or contact lenses except contact lenses when required because of surgery;
- services by an immediate family member or person living with the person requiring treatment;
- any period of custodial care confinement in a hospital or skilled nursing facility;
- service in the Armed Forces of any country; riot; or civil commotion;
- your operating, riding in, or descending from any aircraft, other than while a fare-paying passenger on a licensed, commercial, non-military aircraft;
- expenses for home health care services, unless provided in lieu of a hospital confinement;
- your commission of a felony;
- suicide or attempted suicide or any intentionally self-inflicted injuries, while sane or insane;
- dental care and treatment, except that required by injury and rendered within 90 days of the injury;
- treatment which is determined to be experimental or investigational;
- injury sustained while you are:
  (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or
  (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician;
- treatment of deviated nasal septum, including submucous resection and/or surgical correction;
- expenses in connection with an organ transplant;
- expenses for routine physical exams (unless required by law); and
- any expense incurred after the date the policy terminates.

***Pre-Existing Conditions***

A "Pre-existing Condition" means any condition during the 6 months prior to and including the participant's effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment.

Benefits are limited to a maximum of $1,000 for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition. Coverage for pre-existing conditions will be provided once the participant has been covered under the plan for 12 consecutive months, subject to the limitations of the plan.

Every effort has been made to ensure the accuracy of this benefit plan brochure. The exclusions and limitations described above apply to the residents of most states, however state laws do vary. The laws of the participant's state may affect this benefit plan, but these differences in laws generally do not reduce the benefits. This brochure is not a legal document. In the event of a discrepancy, the policy would be the determining factor.

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina; SRC Insurance Services, Inc.; SRC Services, Inc.

# *Questions & Answers – CNA Option I*

*Q* *Who can enroll?*

*A* An active participant in an AmeriCorps program may be eligible for coverage under this special health insurance plan. Coverage can begin immediately unless the participant is covered by another health care plan. There is no family or dependent coverage available under this plan.

Participants who are covered under another plan (other than Medicaid) are not eligible for this benefit. If the coverage under another plan terminates, the participant can request to be covered under this plan. To decline coverage the participant will have to complete a Waiver Form.

*Q* *When does coverage begin and end?*

*A* The coverage is effective on the first day that the participant becomes active in the AmeriCorps program, provided the participant enrolls and does not waive coverage. There is no waiting period. Coverage will end if (1) the participant terminates under the AmeriCorps program, (2) the participant is no longer eligible (unless Continuation of Coverage applies), (3) the policy terminates, or (4) the AmeriCorps program terminates its participation.

*Q* *If the participant leaves the AmeriCorps Program, can the coverage be continued?*

*A* Yes. This plan has a special provision that allows the insured to continue the coverage under the Plan after the AmeriCorps Program has ended, as long as certain requirements are met. An election form for Continuation of Coverage will be mailed to the home address of the insured after SRC is notified of the insured leaving the program.

*Q* *What is an "occurrence" or "cause?"*

*A* An occurrence or cause is an accident or illness. All eligible expenses incurred as a result of the same or related cause (including any complications) is considered as resulting from one injury or sickness.

*Q* *What are "eligible" and "covered" expenses?*

*A* When an expense is considered "eligible" or "covered" it means that the expenses due to an injury or sickness are the type that the plan may pay for and which are not excluded by the plan.

*Q* *Are dental benefits included?*

*A* No. The plan does not include regular dental benefits. However, the plan does pay for the repair of damage caused by an injury to sound natural teeth, up to $250 per tooth per injury.

*Q* *Does the medical plan cover maternity?*

*A* Yes. Maternity is a covered expense and is not considered a pre-existing condition.

*Q* *Are prescription drugs covered?*

*A* Yes. The Plan will pay 50% for all covered prescription drugs.

*Q* *Are physiotherapy benefits covered?*

*A* Yes. Please refer to the Plan Information Summary for limitations on physiotherapy benefits.

*Q* *Which doctors and hospitals may the participant use? Is there a list of providers?*

*A* There are no lists. The participant may use any licensed doctor or certified hospital that the participant chooses, as long as they meet the definitions established under the program.

## *Questions & Answers Continued – CNA Option I*

*Q What does the participant need to take with them when they visit a doctor?*

*A* The participant should always carry the Health Plan Identification Card and an AmeriCorps Medical Claim Form with the participant when they receive medical treatment.

*Q What if a provider refuses to provide treatment unless the participant pays first?*

*A* This is the provider's choice and is not a reflection of the insurer. If the provider is requiring that the participant pays in advance because he/she is unsure of the coverage, the provider should contact SRC at (803) 736-6463 (this number is on the back of the ID Card) to verify coverage and to receive a summary of benefits.

*Q Does the participant have to complete a claim form for every claim?*

*A* If the participant files his/her own claim, a completed AmeriCorps Medical Claim Form will need to be provided with every itemized bill. But if the provider submits the claim, the participant will not need to complete a claim form each time.

*Q Is there a deductible?*

*A* Yes. $100 per Plan Year. The participant will be able to locate the Plan Year effective date from the ID Card.

*Q When will the participant receive the Plan Information Summary and ID Card?*

*A* The AmeriCorps Program Health Care Administrator will give the participant a Plan Information Summary and ID Card after enrollment.

*Q What if the participant has more questions?*

*A* Call the SRC Customer Service Center, Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Spanish-speaking representatives are available.

***The toll-free SRC/AmeriCorps Customer Service Center phone number is:***

# *1-800-788-6557*

# AmeriCorps
# Health Care: CNA Option I

## Plan
## Information Summary

Underwritten by *CONTINENTAL ASSURANCE COMPANY*


Administered by *STRATEGIC RESOURCE COMPANY*

# AmeriCorps Health Care: CNA Option I

## Underwritten by Continental Assurance Company, Chicago, Illinois

This plan is provided under a group insurance policy issued by Continental Assurance Company. This health care plan is designed to reimburse you for eligible medical expenses you incur as a result of non-occupational accidents or sickness. You may obtain a copy of the policy by sending a written request to: SRC/AmeriCorps, PO Box 23907, Columbia, SC 29224-3907. The following is a summary of the policy.

### MEDICAL EXPENSE BENEFITS

If you incur expenses while insured due to an injury or sickness as defined in the policy, the plan will pay the usual & customary charges (U & C) for the Eligible Medical Expenses shown below. All Eligible Medical Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one injury or sickness. The amount payable for any one sickness or injury will not exceed the lifetime maximum benefit limit of $50,000 for each occurrence or cause. The expenses must be incurred within 52 weeks from the date of the first payable claim for that condition and you must remain continuously covered during that 52-week period. Benefits are subject to the deductible and co-payment levels, specified benefits set forth under Eligible Medical Expenses, the limitations appearing under Limited Medical Expenses, and the Exclusions.

After satisfaction of a $100 deductible each coverage year, the policy will pay 80% of the usual & customary (U&C) charges incurred for Eligible Medical Expenses up to a coverage year maximum of $3,600. Once the coverage year maximum has been exhausted, the policy will pay 100% of the usual & customary (U&C) charges incurred for Eligible Medical Expenses up to a total lifetime maximum benefit of $50,000 for each separate accident and sickness.

**Eligible Medical Expenses**

Eligible Medical Expenses are as follows: fees for diagnosis and treatment by a doctor, surgeon, registered nurse, professional anesthetist or radiologist; hospital charges; laboratory, diagnostic and X-ray examinations; rental charges for durable medical equipment, or the purchase of this equipment, whichever is less; prescription drugs; and emergency professional ambulance service to the nearest hospital.

**Limited Medical Expenses**

Benefits under the policy are limited as follows: 1) Benefits for hospital room and board charges are limited to the normal charge for semi-private accommodation, or $600 per day, whichever is less. Intensive care facility charges are limited to the normal charge, or $1,200 per day, whichever is less. 2) Hospital services (in- or outpatient) other than room and board charges are limited to $2,000 per Plan Year. 3) Benefits for eligible expenses incurred due to drug and alcohol abuse are limited to 60 visits per any 12-month period, up to $35 per visit (outpatient) and $10,000 (inpatient). No coverage is provided for more than one inpatient or outpatient occurrence per lifetime. 4) Benefits for eligible expenses incurred due to a motor vehicle accident are limited to $10,000. 5) Benefits for eligible expenses incurred due to sports-related accidents (interscholastic, intercollegiate, club or professional) are limited to $5,000. 6) Benefits for eligible expenses for emergency professional ambulance services to the nearest hospital are limited to $250. 7) Benefits for eligible expenses incurred for specified therapies, including acupuncture and physical therapy, are limited to $10,000 (inpatient) and $1,000 (outpatient), and if immediately following a covered hospital confinement or surgery. 8) Prescription drugs covered up to 50%.

### EXCLUSIONS

No benefits are payable under the policy for expenses: 1) in excess of usual & customary charges or which are not eligible expenses; 2) used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered usual & customary; 3) payable under any occupational benefit plan, Workers' Compensation Act or similar law, automobile medical payments or no-fault plans, public assistance programs, government plans, or any other valid and collectible group insurance; 4) for care or treatment which is not medically necessary, including preventative medicines, routine physical examinations (unless required by law), or any other examination where there is no objective indication of impairment of normal health (including, but not limited to, infertility treatment and birth control); 5) due to any injury occurring while performing duties under the AmeriCorps program, whether or not you are or could be covered under Workers' Compensation or any similar program; 6) resulting from war, declared or undeclared; 7) not approved by a physician; 8) cosmetic surgery, except for (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part, (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy; 9) for eye examinations for the purpose of prescribing corrective lenses or for the fitting of glasses; 10) glasses, hearing aids, or contact lenses except contact lenses when required because of surgery; 11) for services rendered by an immediate family member or someone who lives with you; 12) any period of custodial care confinement in a hospital or skilled nursing facility; 13) service in the armed forces of any country; riot; or civil commotion; 14) resulting from flying (except as a fare-paying passenger on a regularly scheduled airline, or under the direction of Military Airlift Command (MAC) of this or any other country); 15) expenses for home health care services, unless provided in lieu of a hospital confinement; 16) resulting from your commission of a felony; 17) resulting from self-inflicted injury or sickness, suicide, or any attempt at such; 18) for dental care and treatment, except that required by Injury and rendered within 90 days of the Injury, 19) treatment which is determined to be experimental or investigational; 20) resulting from injury sustained while you are (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a physician; 21) for treatment of deviated nasal septum, including submucous resection and/or surgical correction; and 22) in connection with an organ transplant.

### PRE-EXISTING CONDITIONS

A "Pre-existing Condition" means any condition during the 6 months prior to and including your effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment. Does not apply to pregnancy.

During your first 12 months of coverage under this plan, benefits paid for Eligible Medical Expenses due to pre-existing conditions will not exceed $1,000. Coverage for pre-existing conditions will be provided once you have been covered under this plan for 12 consecutive months. This time requirement will be reduced by any creditable coverage you have had.

### FILING A CLAIM

When you have a medical claim, fill out the claim form completely, attaching all bills and send to AmeriCorps Claims c/o SRC, PO Box 23907, Columbia, SC 29224-3907. Your benefits are paid directly to you, except when you assign your benefits to your medical provider, and will be mailed to you along with an Explanation of Benefits. If a claim is denied, you will be notified in writing of the reason for the denial. You will have 60 days to request a review of a denied claim.

### TERMINATION OF COVERAGE

Your coverage under the policy will terminate upon the earliest of the following: 1) when you are no longer eligible for coverage; 2) the date the Participating Organization through which you are covered is no longer covered; 3) the date the policy terminates; 4) the date you enter the Armed Forces on full-time duty; 5) the date you become eligible for any other group medical benefit program.

### CONTINUATION OF COVERAGE

Terminated insureds who become ineligible for coverage under the plan may choose to continue their coverage by paying their own premiums. Once the termination date is reported via the Roster, SRC will mail a Continuation of Coverage Election Form to the person's last known home address.

# AmeriCorps CNA Option II – Overview*

## General Information

- No pre-certification/approval is required.
- Per cause benefits are payable once for each accident or illness.
- Expenses must be incurred within 52 weeks of the first covered claim for any one occurrence or cause.

## Plan Benefits

| | |
|---|---|
| Plan Year Deductible | $100 |
| Eligible Expenses Coinsurance Maximum | $4,500 |
| Percentage paid by plan before Coinsurance Maximum is satisfied [2] | 80% |
| Individual Out-of-Pocket Maximum (includes deductible) | $1000 |
| Percentage paid by plan after Coinsurance Maximum is satisfied [2] | 100% |
| Per Cause Maximum Benefit | $50,000 |
| Pre-existing Conditions Maximum Benefit (does not apply to pregnancy) [5] | $5,000 |
| Prescription Drugs [1] | Covered |
| Mental & Nervous Disorders | Covered |
| Elective Termination of Pregnancy | Covered |
| Chiropractic Services | Covered |
| Preventative Exam Benefit | |
| Maximum Benefit [1,4] | $150 |
| **Dental Benefits** | Covered |

## Benefit Limits

| | |
|---|---|
| Hospital Benefits | |
| Daily Room & Board Maximum [6] | $600 |
| Daily Intensive Care Facility Maximum [6] | $1,200 |
| Hospital Services other than Room and Board (in- or outpatient) [4] | $2,000 |
| Substance Abuse Treatment [3] | |
| Outpatient, Maximum number of visits allowed | 60 |
| Maximum per visit Benefit | $35 |
| Inpatient Maximum [4] | $10,000 |
| Maximum Benefit for Injury due to Motor Vehicle Accident | $10,000 |
| Maximum Benefit for Injury due to Organized Sports Injury | $5,000 |
| Specified Therapies (including acupuncture and physical therapy) | |
| Outpatient Maximum Benefit [7] | $1,000 |
| Inpatient Maximum Benefit | $10,000 |
| Injury to Sound Natural Teeth, Maximum Benefit per Tooth | $250 |
| Emergency Professional Ambulance Service Maximum Benefit | $250 |

## Accidental Death Benefit

| | |
|---|---|
| Maximum Benefit | $10,000 |

## Monthly Premiums

| | |
|---|---|
| Standard Cost | $124.00 |
| Continuation of Coverage | $126.48 |

***Full Details Will Be Provided In The Plan Information Summary After Enrollment.***

1. Subject to coinsurance.
2. Where benefit is expressed as a percentage, usual & customary (U&C) fee levels will be the basis of payment.
3. Maximum of one occurrence for in- and/or out-patient.
4. Per plan year.
5. Benefits for pre-existing conditions are limited to the amount shown when incurred during the first 12 months of coverage. Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan.
6. Plan will pay the maximum or actual Hospital Charges, whichever is less (room & board based on semi-private room).
7. Covered only if immediately following covered surgery or hospital confinement.

# *Exclusions & Limitations – CNA Option II*

*No coverage is provided for loss caused by or resulting from:*

- work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- acts of war (declared or undeclared);
- expenses which are not approved by a physician;
- cosmetic surgery. This does not apply to:
  (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
  (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or
  (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
- eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses;
- glasses, hearing aids, or contact lenses except contact lenses when required because of surgery;
- services by an immediate family member or person living with the person requiring treatment;
- any period of custodial care confinement in a hospital or skilled nursing facility;
- service in the Armed Forces of any country; riot; or civil commotion;
- your operating, riding in, or descending from any aircraft, other than while a fare-paying passenger on a licensed, commercial, non-military aircraft;
- expenses for home health care services, unless provided in lieu of a hospital confinement;
- your commission of a felony;
- suicide or attempted suicide or any intentionally self-inflicted injuries, while sane or insane;
- dental care and treatment, except that required by injury and rendered within 90 days of the injury;
- treatment which is determined to be experimental or investigational;
- injury sustained while you are:
  (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or
  (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician;
- treatment of deviated nasal septum, including submucous resection and/or surgical correction;
- expenses in connection with an organ transplant; and
- any expense incurred after the date the policy terminates.

*What is not covered under the Accidental Death Benefit:*

- death resulting from sickness of any kind;
- death which occurs more than 12 months from the originating accident; and
- death due to: use of alcohol, intoxicants or drugs; self-inflicted injury or suicide; war, service in the Armed Forces; riot, civil commotion or terrorism; or flying (unless as a fare-paying passenger on a regularly scheduled airline or on Military Airlift Command).

*What is not covered under the Dental Plan:*

- procedures begun before the insured became covered;
- any procedure begun after coverage ends.
- treatment that is unnecessary, experimental, or does not offer a favorable prognosis;
- expenses covered under another group plan or coverage required by law;
- expenses which the participant is not legally obligated to pay;
- elective or cosmetic treatment;
- correction of congenital malformations;
- procedures involving vertical dimension, correction of attrition or abrasion, occlusion, splinting, or bite analysis;
- services in any way related to TMJ or myofascial pain;
- orthognathic surgery;
- orthodontic treatment;
- prescribed drugs, analgesics, or anesthetics;
- instruction for diet, plaque control, and oral hygiene;
- charges for implants or their removal and other customized services or attachments;
- treatment of malignancies, cysts, and neoplasms; and
- charges for forms or missed appointments.

*Pre-Existing Conditions*

A "Pre-existing Condition" means any condition during the 6 months prior to and including the participant's effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment.

Benefits are limited to a maximum of $5,000 for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition. Coverage for pre-existing conditions will be provided once the participant has been covered under the plan for 12 consecutive months, subject to the limitations of the plan.

Every effort has been made to ensure the accuracy of this benefit plan brochure. The exclusions and limitations described above apply to the residents of most states, however state laws do vary. The laws of the participant's state may affect this benefit plan, but these differences in laws generally do not reduce the benefits. This brochure is not a legal document. In the event of a discrepancy, the policy would be the determining factor.

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina;
SRC Insurance Services, Inc.; SRC Services, Inc.

# Americorps
# CNA Option II Summary

## Medical Coverage

**A Limited Benefit Accident and Sickness Medical Plan.**

- Use any doctor or hospital you want.
- Covers non-work related expenses.
- ***Inpatient and Outpatient Benefits:*** After satisfaction of a $100 deductible each coverage year, the policy will pay 80% of the usual & customary charges incurred for covered medical expenses up to a coverage year maximum of $3,600. Once the coverage year maximum has been exhausted, the policy will pay 100% of the usual & customary charges incurred for covered medical expenses up to a total lifetime maximum benefit of $50,000 for each separate accident and sickness. Benefits will be paid, subject to any applicable limitation, for covered medical expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Charges must be incurred within 52 weeks from the date of the first covered loss for each separate Accident or Sickness and while the Covered Person's coverage is in force. No benefit will be paid for a charge that is incurred in connection with a particular Accident or Sickness if it is incurred more than one year after the date of the first covered loss for that Accident or Sickness.
- ***Covered Medical Expenses***:
  - Fees for diagnosis and treatment by a doctor, surgeon, registered nurse, professional anesthetist, or radiologist;
  - Hospital charges;
  - Laboratory, diagnostic, and x-ray examinations;
  - Rental charges for durable medical equipment, or the purchase of this equipment, whichever is less;
  - Emergency professional ambulance service to the nearest hospital; and
  - Prescription drugs.
- ***Limited Medical Expenses:*** Certain covered expenses are limited to a scheduled amount or maximum benefit. A complete listing of these is available in the Plan Information Summary. These limitations involve covered charges for hospital room and board; motor vehicle accidents; certain sports accidents; expenses for ambulances; acupuncture; physical therapy; diagnosis and treatment of certain skin disorders; and treatment of alcohol and drug abuse disorders.
- ***Preventative Exam Benefit:*** Provides benefits for routine preventative exams. The Plan pays 80%, up to a maximum benefit of $150 per Plan Year. This routine exam covers expenses for a physical history, a review of vital signs, a general exam of external and internal organs and systems, and any associated laboratory and x-ray procedures.
- ***Pre-existing Conditions:*** Benefits are limited to a maximum of $5,000 for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition (does not include pregnancy). Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan. This time requirement may be reduced by any creditable coverage the participant may have had.
- ***Accidental Death Benefit:*** The Plan also provides a valuable 24-hour accidental death benefit of $10,000.

## Dental Coverage

The Plan offers a dental benefit which includes a $1,500 Plan Year maximum benefit after a $25 deductible. Participant s may use any dentist he/she wants to, and the dental plan covers many common services.

| Treatment | Plan Pays |
|---|---|
| Diagnostic & Preventative | 80% of U&C* |
| Fillings | $30 to $85 |
| Oral Surgery | $25 to $80 |
| Perio & Endodontic** | Up to $200 |

*U&C = Usual & Customary Charges
**12 Month Waiting Period

*Este folleto contiene un resumen en inglés del Plan de AmeriCorps. Si usted tiene dificultad en entender cualquier parte de este folleto llame al número gratuito 1-800-788-6557. Nuestros representantes de consulta están disponibles de 8:00 a.m. a 8:00 p.m., de lunes a viernes (hora del Este) para darle asistencia en español.*

# *Exclusions & Limitations – CNA Option II*

***No coverage is provided for loss caused by or resulting from:***

- work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
- acts of war (declared or undeclared);
- expenses which are not approved by a physician;
- cosmetic surgery. This does not apply to:
  (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
  (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or
  (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy.
- eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses;
- glasses, hearing aids, or contact lenses except contact lenses when required because of surgery;
- services by an immediate family member or person living with the person requiring treatment;
- any period of custodial care confinement in a hospital or skilled nursing facility;
- service in the Armed Forces of any country; riot; or civil commotion;
- your operating, riding in, or descending from any aircraft, other than while a fare-paying passenger on a licensed, commercial, non-military aircraft;
- expenses for home health care services, unless provided in lieu of a hospital confinement;
- your commission of a felony;
- suicide or attempted suicide or any intentionally self-inflicted injuries, while sane or insane;
- dental care and treatment, except that required by injury and rendered within 90 days of the injury;
- treatment which is determined to be experimental or investigational;
- injury sustained while you are:
  (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or
  (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician;
- treatment of deviated nasal septum, including submucous resection and/or surgical correction;
- expenses in connection with an organ transplant; and
- any expense incurred after the date the policy terminates.

***What is not covered under the Accidental Death Benefit:***

- death resulting from sickness of any kind;
- death which occurs more than 12 months from the originating accident; and
- death due to: use of alcohol, intoxicants or drugs; self-inflicted injury or suicide; war, service in the Armed Forces; riot, civil commotion or terrorism; or flying (unless as a fare-paying passenger on a regularly scheduled airline or on Military Airlift Command).

***What is not covered under the Dental Plan:***

- procedures begun before the insured became covered;
- any procedure begun after coverage ends.
- treatment that is unnecessary, experimental, or does not offer a favorable prognosis;
- expenses covered under another group plan or coverage required by law;
- expenses which the participant is not legally obligated to pay;
- elective or cosmetic treatment;
- correction of congenital malformations;
- procedures involving vertical dimension, correction of attrition or abrasion, occlusion, splinting, or bite analysis;
- services in any way related to TMJ or myofascial pain;
- orthognathic surgery;
- orthodontic treatment;
- prescribed drugs, analgesics, or anesthetics;
- instruction for diet, plaque control, and oral hygiene;
- charges for implants or their removal and other customized services or attachments;
- treatment of malignancies, cysts, and neoplasms; and
- charges for forms or missed appointments.

***Pre-Existing Conditions***

A "Pre-existing Condition" means any condition during the 6 months prior to and including the participant's effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment.

Benefits are limited to a maximum of $5,000 for eligible expenses incurred during the first 12 months of coverage if they are due to a pre-existing condition. Coverage for pre-existing conditions will be provided once the participant has been covered under the plan for 12 consecutive months, subject to the limitations of the plan.

Every effort has been made to ensure the accuracy of this benefit plan brochure. The exclusions and limitations described above apply to the residents of most states, however state laws do vary. The laws of the participant's state may affect this benefit plan, but these differences in laws generally do not reduce the benefits. This brochure is not a legal document. In the event of a discrepancy, the policy would be the determining factor.

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina; SRC Insurance Services, Inc.; SRC Services, Inc.

# *Questions & Answers – CNA Option II*

*Q Who can enroll?*

*A* An active participant in an AmeriCorps program may be eligible for coverage under this special health insurance plan. Coverage can begin immediately, unless the participant is covered by another health care plan. There is no family or dependent coverage available under this plan.

Participants who are covered under another plan (other than Medicaid) are not eligible for this benefit. If the coverage under another plan terminates, the participant can request to be covered under this plan. To decline coverage the participant will have to complete a Waiver Form.

*Q When does coverage begin and end?*

*A* The coverage is effective on the first day that the participant will become active in the AmeriCorps program, provided the participant enrolls and does not waive coverage. There is no waiting period. Coverage will end if (1) the participant terminates under the AmeriCorps program, (2) the participant is no longer eligible (unless Continuation of Coverage applies), (3) the policy terminates, or (4) the AmeriCorps Program terminates its participation.

*Q If the participant leaves the AmeriCorps Program, can the coverage be continued?*

*A* Yes. This plan has a special provision that allows the insured to continue coverage under the Plan after the AmeriCorps Program has ended, as long as certain requirements are met. An election form for Continuation of Coverage will be mailed to the insured's home address after SRC is notified of the insured's leaving the program.

*Q What is an "occurrence" or "cause?"*

*A* An occurrence or cause is an accident or illness. All eligible expenses incurred as a result of the same or related cause (including any complications) is considered as resulting from one injury or sickness.

*Q What are "eligible" and "covered" expenses?*

*A* When an expense is considered "eligible" or "covered" it means that the expenses due to an injury or sickness are the type that the plan may pay for and which are not excluded by the plan.

*Q Are dental benefits included?*

*A* Yes. The plan does include dental benefits. The dental benefit includes a $1,500 Plan Year maximum benefit after a $25 deductible. Participants may use any dentist he/she wants, and the dental plan covers many common services.

*Q Is the participant required to use a Dental Claim Form?*

*A* Yes. The Dental Claim Form is a separate form from the standard Medical Claim Form.

*Q Does the medical plan cover maternity?*

*A* Yes. Maternity is a covered expense and is not considered a pre-existing condition.

*Q Are physiotherapy benefits services covered?*

*A* Yes. Please refer to the Plan Information Summary for limitations on physiotherapy benefits.

*Q Are prescription drugs covered?*

*A* Yes. The Plan will pay 80% until $4,500 in eligible medical expenses has been met, then the Plan will pay 100% for the rest of the Plan Year.

# *Questions & Answers Continued – CNA Option II*

*Q* *Which doctors and hospitals may the participant use? Is there a list of providers?*

*A* There are no lists. The participant are free to use any licensed doctor or certified hospital that he/she chooses, as long as they meet the definitions established under the program.

*Q* *What does the participant need to take with them when they visit a doctor or dentist?*

*A* The participant should always carry the Health Plan Identification Card and an AmeriCorps Claim Form with them when the participant receives treatment.

*Q* *What if a provider refuses to provide treatment unless the participant pays first?*

*A* This is the provider's choice and is not a reflection of the insurer. If the provider is requiring that the participant pay in advance because he/she is unsure of the coverage, the provider should contact SRC at (803) 736-6463 (this number is on the back of the ID Card) to verify coverage and to receive a summary of benefits.

*Q* *Does the participant have to complete a claim form for every claim?*

*A* If the participant files their own claim, a completed AmeriCorps Medical Claim Form will need to be provided with every itemized bill. But if the provider submits the claim, the participant will not need to complete a claim form each time.

*Q* *Is there a deductible?*

*A* Yes. $100 per Plan Year for medical expenses and $25 for dental expenses. The participant will be able to locate the plan year effective date from the ID Card.

*Q* *What is a beneficiary?*

*A* The beneficiary is the person the participant names to receive the benefits of the accidental death coverage which may be payable in the event of the participant's death. The participant can name anyone he/she wants to be the beneficiary.

*Q* *When will the participant receive the Plan Information Summary and ID Card?*

*A* The AmeriCorps Program Health Care Administrator will give the participant a Plan Information Summary and ID Card after enrollment.

*Q* *What if the participant has more questions?*

*A* Call the SRC Customer Service Center, Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Spanish-speaking representatives are available.

***The toll-free SRC/AmeriCorps Customer Service Center phone number is:***

# *1-800-788-6557*

# AmeriCorps
# Health Care: CNA Option II

## Plan
## Information Summary

Underwritten by *CONTINENTAL ASSURANCE COMPANY*


Administered by *STRATEGIC RESOURCE COMPANY*

# AmeriCorps Health Care: CNA Option II

## Underwritten by Continental Assurance Company, Chicago, Illinois

This plan is provided under a group insurance policy issued by Continental Assurance Company. This health care plan is designed to reimburse you for eligible medical expenses you incur as a result of non-occupational accidents or sickness. You may obtain a copy of the policy by sending a written request to: SRC/AmeriCorps, PO Box 23907, Columbia, SC 29224-3907. The following is a summary of the policy.

### MEDICAL EXPENSE BENEFITS

If you incur expenses while insured due to an injury or sickness as defined in the policy, the plan will pay the usual & customary charges (U & C) for the Eligible Medical Expenses shown below. All Eligible Medical Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one injury or sickness. The amount payable for any one sickness or injury will not exceed the lifetime maximum benefit limit of $50,000 for each occurrence or cause. The expenses must be incurred within 52 weeks from the date of the first payable claim for that condition and you must remain continuously covered during that 52 week period. Benefits are subject to the deductible and co-payment levels, specified benefits set forth under Eligible Medical Expenses, the limitations appearing under Limited Medical Expenses, and the Exclusions.

After satisfaction of a $100 deductible each coverage year, the policy will pay 80% of the usual & customary (U&C) charges incurred for Eligible Medical Expenses up to a coverage year maximum of $3,600. Once the coverage year maximum has been exhausted, the policy will pay 100% of the usual & customary (U&C) charges incurred for Eligible Medical Expenses up to a total lifetime maximum benefit of $50,000 for each separate accident and sickness.

**Eligible Medical Expenses**

Eligible Medical Expenses are as follows: fees for diagnosis and treatment by a doctor, surgeon, registered nurse, professional anesthetist or radiologist; hospital charges; laboratory, diagnostic and X-ray examinations; rental charges for durable medical equipment, or the purchase of this equipment, whichever is less; prescription drugs; and emergency professional ambulance service to the nearest hospital. The routine preventative exam covers expenses for a physical history, a review of vital signs, a general exam of external and internal organs and systems, and any associated laboratory and x-ray procedures.

**Limited Medical Expenses**

Benefits under the policy are limited as follows: 1) Benefits for hospital room and board charges are limited to the normal charge for semi-private accommodation, or $600 per day, whichever is less. Intensive care facility charges are limited to the normal charge, or $1,200 per day, whichever is less. 2) Hospital services (in- or outpatient) other than room and board charges are limited to $2,000 per Plan Year. 3) Benefits for eligible expenses incurred due to drug and alcohol abuse are limited to 60 visits per any 12-month period, up to $35 per visit (outpatient) and $10,000 (inpatient). No coverage is provided for more than one inpatient or outpatient occurrence per lifetime. 4) Benefits for eligible expenses incurred due to a motor vehicle accident are limited to $10,000. 5) Benefits for eligible expenses incurred due to sports-related accidents (interscholastic, intercollegiate, club or professional) are limited to $5,000. 6) Benefits for eligible expenses for emergency professional ambulance services to the nearest hospital are limited to $250. 7) Benefits for eligible expenses incurred for specified therapies, including acupuncture and physical therapy, are limited to $10,000 (inpatient) and $1,000 (outpatient), and if immediately following a covered hospital confinement or surgery. 8) Benefits are payable for one routine preventative exam per Plan Year up to a maximum benefit of $150 per Plan Year.

### ACCIDENTAL DEATH BENEFIT

The plan includes a $10,000 accidental death benefit. In the event of your accidental death while you are covered under the plan, this benefit will be paid to your named beneficiary. Death must occur within 12 months of originating accident.

### DENTAL BENEFIT

The plan offers a dental benefit which includes a $1,500 coverage year maximum benefit after a $25 deductible. Insureds may use any licensed dentist they want to. The dental plan covers most common services.

### EXCLUSIONS

No benefits are payable under the policy for expenses: 1) in excess of usual & customary charges or which is not eligible expenses; 2) used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered usual & customary; 3) payable under any occupational benefit plan, Workers' Compensation Act or similar law, automobile medical payments or no-fault plans, public assistance programs, government plans, or any other valid and collectible group insurance; 4) for care or treatment which is not medically necessary, including preventative medicines, routine physical examinations (unless required by law), or any other examination where there is no objective indication of impairment of normal health (including, but not limited to, infertility treatment and birth control), except as provided under the policy for CNA Option II; 5) due to any injury occurring while performing duties under the AmeriCorps program, whether or not you are or could be covered under Workers' Compensation or any similar program; 6) resulting from war, declared or undeclared; 7) not approved by a physician; 8) cosmetic surgery, except for (a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part, (b) reconstructive surgery because of a congenital disease or anomaly of an insured; or (c) reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy; 9) for eye examinations for the purpose of prescribing corrective lenses or for the fitting of glasses; 10) glasses, hearing aids, or contact lenses except contact lenses when required because of surgery; 11) for services rendered by an immediate family member or someone who lives with you; 12) any period of custodial care confinement in a hospital or skilled nursing facility; 13) service in the armed forces of any country; riot; or civil commotion; 14) resulting from flying (except as a fare-paying passenger on a regularly scheduled airline, or under the direction of Military Airlift Command (MAC) of this or any other country); 15) expenses for home health care services, unless provided in lieu of a hospital confinement; 16) resulting from your commission of a felony; 17) resulting from self-inflicted injury or sickness, suicide, or any attempt at such; 18) for dental care and treatment, except that required by Injury and rendered within 90 days of the Injury, 19) treatment which is determined to be experimental or investigational; 20) resulting from injury sustained while you are (a) legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accident occurs; or (b) voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a physician; 21) for treatment of deviated nasal septum, including submucous resection and/or surgical correction; and 22) in connection with an organ transplant.

With respect to the Accidental Death Benefit under the policy for the CNA Option II plan, benefits are not payable if death: 1) results from sickness of any kind; 2) occurs more than 12 months from the date of the originating accident; 3) is due to use of alcohol, intoxicants or drugs; self-inflicted injury or suicide; war; service in the Armed Forces; riot, civil commotion, terrorism; or flying (unless as a fare-paying passenger on a regularly scheduled airline or on Military Airlift Command).

With respect to the Dental benefits under CNA Option II, the following is excluded: 1) procedures begun before the insured became covered; 2) any procedure begun after coverage ends. 3) treatment that is unnecessary, experimental, or does not offer a favorable prognosis; 4) expenses covered under another group plan or coverage required by law; 5) expenses which the participant is not legally obligated to pay; 6) elective or cosmetic treatment; 7) correction of congenital malformations; 8) procedures involving vertical dimension, correction of attrition or abrasion, occlusion, splinting, or bite analysis; 9) services in any way related to TMJ or myofascial pain; 10) orthognathic surgery; 11) prescribed drugs, analgesics, or anesthetics; 12) instruction for diet, plaque control, and oral hygiene; 13) charges for implants or their removal and other customized services or attachments; 14) treatment of malignancies, cysts, and neoplasms; 15) orthodontic treatment; and 16) charges for forms or missed appointments.

### PRE-EXISTING CONDITIONS

A "Pre-existing Condition" means any condition during the 6 months prior to and including your effective date for which medical advice or treatment was sought, or for which symptoms existed which would cause a prudent person to seek diagnosis, care, or treatment. Does not apply to pregnancy.

During your first 12 months of coverage under this plan, benefits paid for Eligible Medical Expenses due to pre-existing conditions will not exceed $5,000. Coverage for pre-existing conditions will be provided once you have been covered under this plan for 12 consecutive months. This time requirement will be reduced by any creditable coverage you have had.

### FILING A CLAIM

When you have a medical claim, fill out the claim form completely, attaching all bills and send to AmeriCorps Claims c/o SRC, PO Box 23907, Columbia, SC 29224-3907. Your benefits are paid directly to you, except when you assign your benefits to your medical provider, and will be mailed to you along with an Explanation of Benefits. If a claim is denied, you will be notified in writing of the reason for the denial. You will have 60 days to request a review of a denied claim.

### TERMINATION OF COVERAGE

Your coverage under the policy will terminate upon the earliest of the following: 1) when you are no longer eligible for coverage; 2) the date the Participating Organization through which you are covered is no longer covered; 3) the date the policy terminates; 4) the date you enter the Armed Forces on full-time duty; 5) the date you become eligible for any other group medical benefit program.

### CONTINUATION OF COVERAGE

Terminated insureds who become ineligible for coverage under the plan may choose to continue their coverage by paying their own premiums. Once the termination date is reported via the Roster, SRC will mail a Continuation of Coverage Election Form to the person's last known home address.

# *AmeriCorps Medical Claim Form*

**MAKE A COPY OF THIS FORM**

## CLAIM FORM INSTRUCTIONS

**Please Print**

1. Make a copy of this form
2. Read both sides of this form
3. Completely fill out Sections 1-4 (Section 5 is optional)
4. Remember to give the insured's Social Security Number

5. Attach itemized bills providing complete information on:
   - Doctor's Name and Address
   - Doctor's Tax Identification Number
   - Patient Name
   - Diagnosis Code ICD-9
   - Date of Service
   - Charges/Cost of each treatment
   - Procedure Codes CPT-4
   - Place of Service Code

***Note:*** *Itemized bills are not:*
- Balance Due Statements
- Explanation of Benefits

6. If your medical provider sends your bill or claim to us, make sure an itemized bill is included.
7. Sign Section 5 if you want benefits paid to your medical provider.

8. If you have a Certificate of Creditable Health Coverage from your previous employer, please attach it to your completed Medical Claim Form and send it to the address at the bottom of this form. Keep a copy for your records.

## SECTION 1: INSURED INFORMATION

| INSURED NAME (LAST, first, middle) | | INSURED SOCIAL SECURITY NUMBER |
|---|---|---|
| | | - - |
| STREET ADDRESS | CITY | STATE ZIP CODE |
| | | |
| PHONE NUMBER | PROGRAM NAME | PROGRAM NUMBER (obtain from I.D. card) |
| | | |

## SECTION 2: CLAIM INFORMATION

| IS THE CLAIM FOR AN | IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | WHEN DID THE ACCIDENT OR ILLNESS OCCUR? |
|---|---|---|
| ❑ ACCIDENT OR ❑ ILLNESS? | ❑ YES ❑ NO | _____ / _____ / _____ MONTH DAY YEAR |

PLEASE EXPLAIN WHAT YOU WERE TREATED FOR AND IF IT WAS AN ACCIDENT, PROVIDE DETAILS ON HOW, WHEN, AND WHERE IT HAPPENED
(use the back of this form or attach a sheet of paper to this form if necessary)

## SECTION 3: PRESCRIPTION DRUG INFORMATION

| | NAME OF MEDICATION (s) | CONDITION BEING TREATED |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

If you have more than five medications, please use the back of this form or attach an additional sheet of paper to this form.

## SECTION 4: ASSIGNMENT OF BENEFITS

**TO BE COMPLETED BY INSURED. DO NOT SIGN IF FEES HAVE ALREADY BEEN PAID.**
I APPROVE THE PAYMENT OF BENEFITS TO THE DOCTOR OR OTHER MEDICAL PROVIDER SHOWN ON THE ITEMIZED BILL (whose Tax Identification Number is included). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS APPROVAL.

| SIGNATURE OF INSURED | DATE |
|---|---|
| | _____ / _____ / _____ MONTH DAY YEAR |

## SECTION 5: AUTHORIZATION

**INSTRUCTIONS: THE AUTHORIZATION SHOULD BE COMPLETED AND SIGNED BY THE INSURED. IF THE INSURED IS UNABLE TO SIGN, THE AUTHORIZATION SHOULD BE COMPLETED AND SIGNED BY THE LEGAL GUARDIAN OR NEXT-OF-KIN.**

To all physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross-Blue Shield, self-insured and prepaid health plans):

You are authorized to permit Continental Assurance Company and its Third Party Administrators, and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus), and disease of

_____
*Print Name of Insured*

I understand the information obtained will only be used by Continental Assurance Company to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to Continental Assurance Company but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

| SIGNED | DATE | RELATIONSHIP TO INSURED IF SIGNED BY OTHER THAN INSURED |
|---|---|---|
| | _____ / _____ / _____ MONTH DAY YEAR | |

IF SIGNED BY OTHER THAN THE INSURED, PLEASE PRINT NAME & ADDRESS AND INCLUDE GUARDIANSHIP PAPERS OR OTHER EVIDENCE OF LEGAL REPRESENTATION.

**SEND MEDICAL CLAIMS TO: Strategic Resource Company • PO Box 23759 • Columbia, SC 29224-3759**
**Please Note: Incomplete forms and the absence of itemized bills may delay the processing of your claim.**

## FRAUD NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN INSURANCE APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE COMMITTING A CRIME AND MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.

*The laws of some states require us to furnish you with the following notice:*

***California:*** Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

***Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

***Florida***: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

***Hawaii:*** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

***New Hampshire:*** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

***Pennsylvania****:* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact, material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina; SRC Insurance Services, Inc.; SRC Services, Inc.

# *AmeriCorps Dental Claim Form*

**MAKE A COPY OF THIS FORM**

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

| PROGRAM NAME | **MAIL CLAIM TO:**<br>SRC Dental<br>P. O. Box 23759<br>Columbia, SC 29224-3759 | **PROVIDERS: 1-803-736-6463**<br>**COVERED PERSON: 1-800-869-0808** |
|---|---|---|
| POLICY # | | |

**PART 1: INSURED** **COMPLETE PART 1, SIGN THE AUTHORIZATION, AND GIVE TO DENTIST**

| PATIENT'S NAME (last, first, middle) | PATIENT'S SOCIAL SECURITY NUMBER<br>- - |
|---|---|
| SEX<br>❑ MALE ❑ FEMALE | PATIENT'S BIRTHDATE<br>MONTH / DAY / YEAR |
| STREET ADDRESS | |
| CITY / STATE / ZIP CODE | |
| IS PATIENT COVERED BY ANOTHER DENTAL PLAN?<br>❑ YES (if yes, indicate) ❑ NO | |
| DENTAL PLAN NAME | |
| GROUP NAME | GROUP NUMBER |
| NAME & ADDRESS OF CLAIMS ADMINISTRATOR | |

I accept this attending dentist's statement and authorize release of information relating hereto. I certify the truth of all personal information contained above. I agree to be responsible for payment of services provided during any ineligible period.

SIGNED (patient) DATE

**AUTHORIZATION**

INSTRUCTIONS: THE AUTHORIZATION SHOULD BE COMPLETED AND SIGNED BY THE INSURED. IF THE INSURED IS UNABLE TO SIGN, THE AUTHORIZATION SHOULD BE COMPLETED AND SIGNED BY THE LEGAL GUARDIAN OR NEXT-OF-KIN.

To all physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross-Blue Shield, self-insured and prepaid health plans):

You are authorized to permit Continental Assurance Company and its Third Party Administrators, and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus), and disease of

_____

*Print Name of Insured*

I understand the information obtained will only be used by Continental Assurance Company to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to Continental Assurance Company but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

| DATE | SIGNED | RELATIONSHIP TO INSURED IF SIGNED BY OTHER THAN INSURED |
|---|---|---|

[If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.]

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina; SRC Insurance Services, Inc.; SRC Services, Inc.

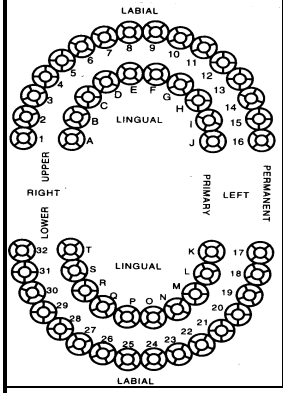
| PART 2: DENTIST | COMPLETE PART 2 AND SEND TO SRC | |
|---|---|---|
| **1.** DENTIST NAME (first, middle, last) | | **2.** DENTIST SOCIAL SECURITY or TIN NUMBER |
| **3.** DENTIST MAILING ADDRESS (street, city, state, zip code) | | **4.** DENTIST LICENSE NUMBER<br>**5.** DENTIST PHONE NUMBER |
| **6.** IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | ❑ YES ❑ NO | IF YES, ENTER BRIEF DESCRIPTION: |
| **7.** IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT? | ❑ YES ❑ NO | IF YES, ENTER BRIEF DESCRIPTION: |
| **8.** ARE ANY SERVICES COVERED BY ANOTHER PLAN? | ❑ YES ❑ NO | IF YES, ENTER BRIEF DESCRIPTION: |
| **9.** IF PROTHESES, IS THIS INITIAL PLACEMENT? | ❑ YES ❑ NO | IF NO, REASON FOR REPLACEMENT, DATE OF PRIOR PLACEMENT: |
| **10.** IS TREATMENT FOR ORTHODONTICS? | ❑ YES ❑ NO | IF SERVICES ALREADY COMMENCED, DATE APPLIANCES PLACED & MONTHS OF TREATMENT REMAINING: |

| **11.** FIRST VISIT DATE CURRENT SERIES: | **12.** PLACE OF TREATMENT<br>❑ OFFICE ❑ ECF ❑ HOSPITAL ❑ OTHER | **13.** RADIOGRAPHS OR MODELS ENCLOSED?<br>❑ YES, HOW MANY? _____ ❑ NO |
|---|---|---|

**14.** PRE-TREATMENT ESTIMATE REQUIRED IF COURSE OF TREATMENT IS EXPECTED TO EXCEED THE LIMIT SPECIFIED IN BENEFIT PACKAGE & ON THE ID CARD.

CHECK ONE: ❑ DENTIST'S PRE-TREATMENT ESTIMATE ❑ DENTIST'S STATEMENT OF ACTUAL SERVICES

**EXAMINATION & TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32. USE CHARTING SYSTEM SHOWN.**

| INDICATE MISSING TEETH WITH AN "X" | TOOTH # OR LETTER | SURFACE | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) | DATE SERVICE PERFORMED: MONTH/DAY/YEAR | PROCEDURE NUMBER | FEE |
|---|---|---|---|---|---|---|
|  | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| REMARKS FOR UNUSUAL SERVICES | | | | | | |

I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS. **TOTAL:**

| SIGNED (DENTIST) | DATE |
|---|---|
| | |

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN INSURANCE APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE COMMITTING A CRIME AND MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.

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*Colorado:* It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

*Florida*: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

*Hawaii:* For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

*New Hampshire:* Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

*Pennsylvania:* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact, material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

# AmeriCorps Dental Coverage Information – CNA Option II

## General Information

***What is the Dental Coverage?*** The Plan pays either a percentage of usual and customary (U&C) charges or a fixed benefit amount for covered dental procedures. Benefits are payable up to $1,500 per coverage year, subject to a $25 deductible each coverage year. The schedule of covered procedures and the benefits the Plan will pay can be found below. Certain types of procedures are subject to waiting periods and frequency limitations.

***What does "usual and customary" mean?*** "Usual and Customary" means the lesser of the usual fee the provider charges for a dental service or supply or the customary charge for the dental service or supply. The customary charge is determined by the insurance company from within the range of charges made for such dental service or supply by other providers of similar training and experience in that general geographic area.

***What is a "deductible"?*** A deductible is the amount of money you must pay for eligible expenses before the Plan begins to pay benefits.

***Do I need approval to have dental work done?*** If the estimated cost of a treatment plan is more than $200, you must turn in a treatment plan to SRC (see "Filing a Claim" in this section) before treatment begins. A pre-treatment estimate is not required for emergency treatment.

## Schedule of Benefits (D2000)

An eligible enrolled person is covered only for the procedures and benefits shown below. **Note:** Coverage A benefits are expressed as a percent of usual and customary charges.

**COVERAGE A - No Waiting Period**

| | |
|---|---|
| D0150 Comprehensive oral exam (a) | 80% |
| D0120 Periodic oral exam (a) | 80% |
| D0140 Limited oral evaluation - problem focused | 80% |
| D9110 Palliative (emergency) treatment of dental pain - minor procedure | 80% |
| D0330 Panoramic film (b), or | 80% |
| D0210 Intraoral - complete series (b) | 80% |
| D0220 Intraoral - perapical, first film (d) | 80% |
| D0240 Intraoral - occlusal film | 80% |
| D0270 Bitewing - single film (e) | 80% |
| D0272 Bitewing - two films (e) | 80% |
| D0274 Bitewing - four films (e) | 80% |
| D1110 Prophylaxis - adult (a) | 80% |

**COVERAGE B – No Waiting Period**

Fillings

| | |
|---|---|
| D2110 Amalgam - one surface, primary | $ 30 |
| D2120 Amalgam - two surfaces, primary | $ 37 |
| D2130 Amalgam - three surfaces, primary | $ 45 |
| D2131 Amalgam - four + surfaces, primary | $ 54 |
| D2140 Amalgam - one surface, permanent | $ 32 |
| D2150 Amalgam - two surfaces, permanent | $ 42 |
| D2160 Amalgam - three surfaces, permanent | $ 50 |
| D2161 Amalgam - four + surfaces, permanent | $ 63 |
| D2330 Resin-based composite - one surface, anterior | $ 40 |
| D2331 Resin-based composite - two surfaces, anterior | $ 50 |
| D2332 Resin-based composite - three surfaces, anterior | $ 64 |
| D2335 Resin-based composite - four + surfaces or involving incisal angle (anterior) | $ 66 |
| D2380 Resin-based composite - one surface, posterior - primary | $ 38 |
| D2381 Resin-based composite - two surfaces, posterior - primary | $ 55 |
| D2382 Resin-based composite - three + surfaces, posterior - primary | $ 80 |
| D2385 Resin-based composite - one surface, posterior - permanent | $ 50 |
| D2386 Resin-based composite - two surfaces, posterior - permanent | $ 68 |
| D2387 Resin-based composite - three surfaces, posterior - permanent | $ 85 |

Oral Surgery

| | |
|---|---|
| D7110 Extraction - single tooth | $ 35 |
| D7120 Extraction - each additional tooth | $ 25 |
| D7130 Root removal - exposed roots | $ 48 |
| D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | $ 50 |
| D7220 Removal of impacted tooth - soft tissue | $ 60 |
| D7230 Removal of impacted tooth - partially bony | $ 70 |
| D7240 Removal of impacted tooth - completely bony | $ 80 |
| D7510 Incision and drainage of abscess - intraoral soft tissue | $ 45 |

Crowns & Bridges

| | |
|---|---|
| D2951 Pin retention - per tooth, in addition to restoration | $ 7 |

**COVERAGE C - Twelve Month Waiting Period**

Periodontics

| | |
|---|---|
| D4210 Gingivectomy or gingivoplasty - per quadrant (f) | $ 100 |
| D4211 Gingivectomy or gingivoplasty - per tooth | $ 30 |
| D4220 Gingival curettage, surgical - per quadrant, by report (g), or | $ 35 |
| D4341 Periodontal scaling & root planing - per quadrant (g) | $ 60 |
| D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis (b) | $ 40 |
| D4910 Periodontal maintenance procedures (following active therapy) (a) | $ 42 |

Endodontics

| | |
|---|---|
| D3110 Pulp cap - direct (excluding final restoration) | $ 15 |
| D3120 Pulp cap - indirect (excluding final restoration) | $ 15 |
| D3220 Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament | $ 25 |
| D3310 Root canal - anterior (excluding final restoration) (c), or | $ 150 |
| D3320 Root canal - bicuspid (excluding final restoration) (c), or | $ 175 |
| D3330 Root canal - molar (excluding final restoration) (c) | $ 200 |
| D3410 Apicoectomy/periradicular surgery - anterior (c), or | $ 150 |
| D3421 Apicoectomy/periradicular surgery - bicuspid (first root) (c), or | $ 175 |
| D3425 Apicoectomy/periradicular surgery - molar (first root) (c) | $ 200 |
| D3426 Apicoectomy/periradicular surgery – (each additional root) | $ 35 |

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 1 procedure per 12 months
(d) Maximum of 1 procedure per office visit
(e) Maximum of 4 films per 12 months
(f) Maximum of once each quadrant per 36 months
(g) Maximum of once each quadrant per 6 months

CNA Underwritten by Continental Assurance Company, a CNA Company, Chicago, Illinois.

SRC Record keeping and administration by Strategic Resource Company, Columbia, South Carolina; SRC Insurance Services, Inc.; SRC Services, Inc.

## Exclusions and Limitations

No benefits will be paid for loss caused by or resulting from:

- Service or supply not shown on the list of covered procedures;
- Any procedure begun after your insurance terminates;
- Any procedure begun before you became insured;
- Any treatment that is elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association;
- The correction of congenital malformations (unless the procedure is performed on a covered person who was covered immediately following birth);
- Appliances, services, or procedures relating to the change or maintenance of vertical dimension, restoration of occlusion, splinting, correction of attrition or abrasion, bite registration, or bite analysis;
- Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, or myofascial pain;
- Orthognathic surgery;
- Prescribed drugs, pre-medication, analgesia, or general anesthesia;
- Any instruction for diet, plaque control, and oral hygiene;
- Dental disease, defect, or injury caused by a declared or undeclared war or any act of war;
- Charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, over-dentures and any associated surgery, or other customized services or attachments;
- Treatment of malignancies, cysts, and neoplasms;
- Orthodontic treatment;
- Failure to keep a scheduled visit or charges for the completion of any claim forms;
- Any procedure, determined by the insurance company, that is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement, or that is experimental in nature;
- Service or supply rendered by someone who is related to a covered person by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law), or adoption or is normally a member of the covered person's household;
- Any procedure, service, or supplies that are included as covered medical expenses under another group medical expense benefit plan;
- Expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type, and individual automobile "no-fault" coverage);
- Expenses provided or paid for by any governmental program or law, except as to charges that the person is legally obligated to pay; and
- Charges in excess of usual and customary fee levels, based on the 90th percentile of the Medicode MDR tables.

The procedures listed above will also not be recognized toward satisfaction of any deductible amount.

## Filing a Claim

***How do I file a claim?*** This section contains a sample claim form for Dental coverage containing instructions on how to fill it out. You should make a photocopy of the sample form for use whenever you make a claim for services rendered or a pre-treatment estimate. Send your completed form to: CLAIMS, PO Box 23759, Columbia, SC 29224-3759. You may request claim forms by writing to this address. Your dental provider may prefer to file a claim for you using his or her own form. But if you have a claim, you must send in a signed claim form of the type contained in this booklet. This will help ensure prompt processing of your claim. A completed claim form must be submitted within one year of the date of the loss. For Claims Customer Service call 1-800-869-0808, Monday through Friday, 8:30 a.m. to 4:00 p.m. ET.

***How do I appeal a denied claim?*** If all or a part of your claim is denied, you will be notified in writing. This notice will include detailed reasons why the claim was denied and an explanation of how to appeal for reconsideration of the decision. If you disagree with the decision, you may request a review within 60 days. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and including any additional documentation that you feel would support a further review of your claim. Your claim will be reviewed and a decision will be issued within 60 days. Under some circumstances, the insurer can secure a 60-day extension.

## AMERICORPS CNA OPTION II – BENEFICIARY CHANGE FORM

**INSTRUCTIONS: Complete the bottom portion of this form (BENEFICIARY DESIGNATION FORM) and return to your program director. Keep this top portion for future use if you wish to change your beneficiary.**

### A. INFORMATION ABOUT YOU

SOCIAL SECURITY NUMBER _____-_____-_____ | FIRST NAME | MIDDLE INITIAL | LAST NAME

MAILING ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE (_____) _____-_____ | BIRTH DATE _____/_____/_____ (MM DD YY) | SEX ❑ M ❑ F

PRINT NAME_____ YOUR SIGNATURE _____ DATE _____/_____/_____ (MM DD YY)

PROGRAM NUMBER 0 0 0 ☐ ☐ ☐ ☐ ☐ | PROGRAM NAME

### B. WHO IS YOUR BENEFICIARY?

FIRST NAME | INITIAL | LAST NAME

WHAT IS YOUR BENEFICIARY'S RELATIONSHIP TO YOU? ❑ Spouse ❑ Child ❑ Brother/Sister ❑ Parent ❑ Other (specify) _____



---

## AMERICORPS CNA OPTION II – BENEFICIARY DESIGNATION FORM

**INSTRUCTIONS: Complete this portion and return to your program director.**

### A. INFORMATION ABOUT YOU

SOCIAL SECURITY NUMBER _____-_____-_____ | FIRST NAME | MIDDLE INITIAL | LAST NAME

MAILING ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE (_____) _____-_____ | BIRTH DATE _____/_____/_____ (MM DD YY) | SEX ❑ M ❑ F

PRINT NAME_____ YOUR SIGNATURE _____ DATE _____/_____/_____ (MM DD YY)

PROGRAM NUMBER 0 0 0 ☐ ☐ ☐ ☐ ☐ | PROGRAM NAME

### B. WHO IS YOUR BENEFICIARY?

FIRST NAME | INITIAL | LAST NAME

WHAT IS YOUR BENEFICIARY'S RELATIONSHIP TO YOU? ❑ Spouse ❑ Child ❑ Brother/Sister ❑ Parent ❑ Other (specify) _____

# AmeriCorps Accidental Death Insurance Proof of Loss Form

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN INSURANCE APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE COMMITTING A CRIME AND MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.

CNA **Continental Assurance Company, A CNA Company**

***The laws of some states require us to furnish you with the following notice:***

***California:*** Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

***Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

***Florida***: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

***Hawaii:*** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

***New Hampshire:*** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

***Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact, material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

## INSTRUCTIONS FOR FILING A CLAIM

THIS FORM IS FOR ACCIDENTAL DEATH PROCEEDS ONLY.
THIS CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

To the Administrator:
A. Submit completed form to the assigned Claim Office with a certified Death Certificate and Beneficiary Designation
B. If there is no designated Beneficiary, the back of the form should be completed and notarized.
C. If claim is for accidental death, Authorization to Release Information (CL423269) must be submitted.

| NAME OF INSURED (Last Name) (First Name) (Middle Initial) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | SEX ☐ M ☐ F |
|---|---|---|---|
| | | | |

| ADDRESS (Street) (City) (State) (Zip Code) |
|---|
| |

PLEASE CHECK THE APPROPRIATE BLOCK REGARDING THE INSURED'S PARTICIPATION STATUS.

☐ ACTIVE ☐ VACATION/PERSONAL LEAVE ☐ PROGRAM TERMINATION (LACK OF HOURS)
☐ SICK/MEDICAL LEAVE ☐ VOLUNTARY TERMINATION ☐ OTHER, PLEASE SPECIFY _____

| DATE JOINED AMERICORPS | EFFECTIVE DATE OF INSURANCE | AMOUNT OF INSURANCE ACCIDENTAL DEATH COVERAGE |
|---|---|---|
| | | |
| **LAST DATE OF SERVICE** | **DATE OF DEATH** | **PREMIUM PAID THROUGH DATE** |
| | | |

***IF CLAIM IS FOR ACCIDENTAL DEATH BENEFITS, BE SURE TO ATTACH A COPY OF POLICE REPORT, AUTOPSY/CORONER'S REPORT.***

## BENEFICIARY INFORMATION

| NAME OF BENEFICIARY (Last Name) (First Name) (Middle Initial) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | SEX ☐ M ☐ F |
|---|---|---|---|
| | | | |

| ADDRESS (Street) (City) (State) (Zip Code) |
|---|
| |

| RELATIONSHIP TO DECEASED | NAME AND ADDRESS OF LEGAL GUARDIAN IF BENEFICIARY IS A MINOR |
|---|---|
| | |

| DOES THE DECEASED HAVE ANY OTHER LIFE INSURANCE? ☐ YES ☐ NO | IF YES, WITH WHAT COMPANY? | WHAT IS THE AMOUNT OF THE OTHER LIFE INSURANCE? |
|---|---|---|
| | | |

**CERTIFICATION**: Under penalties of perjury, I certify that:
(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
(2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and payments other than interest and dividends).

**INSTRUCTIONS:** You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

| HAS AN ASSIGNMENT BEEN TAKEN? ☐ YES (*If so, please attach.*) ☐ NO | SIGNATURE OF BENEFICIARY OR LEGAL GUARDIAN IF BENEFICIARY IS A MINOR | DATE |
|---|---|---|
| | | |

## AMERICORPS ADMINISTRATOR'S CERTIFICATION

| NAME OF AMERIPCORPS PROGRAM | PROGRAM NUMBER |
|---|---|
| | |

| ADDRESS (Street) (City) (State) (Zip Code) | TELEPHONE # ( ) |
|---|---|
| | |

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF:

| SIGNATURE OF AUTHORIZED REPRESENTATIVE | TITLE | DATE SIGNED |
|---|---|---|
| | | |

THE ISSUANCE OF THIS BLANK FORM IS NOT AN ADMISSION OF THE EXISTENCE OF ANY INSURANCE NOR DOES IT RECOGNIZE THE VALIDITY OF ANY CLAIM AND IS WITHOUT PREJUDICE TO THE COMPANY'S LEGAL RIGHTS IN THE PREMISES.

**PLEASE SEND COMPLETED FORMS TO:**
SRC Claims Department
P.O. Box 23759
Columbia, SC 29224-3759

**PLEASE NOTE:**
***Failure to complete all sections of this form may result in delayed payment of claims.***

# Preference Beneficiary's Affidavit

Continental Assurance Company,
A CNA Company

THIS AFFIDAVIT RELATES TO A CLAIM FOR BENEFITS UNDER THE POLICY IDENTIFIED BELOW, ISSUED BY CONTINENTAL ASSURANCE COMPANY, HEREINAFTER CALLED THE COMPANY.

| POLICY | CERTIFICATE NUMBER | NAME OF DECEASED |
|---|---|---|
| | | |

NOTE: This affidavit is to be used whenever no beneficiary was designated or no designated beneficiary survived the deceased. It is to be completed only by the person or one of the persons within the first surviving class of the following classes of successive preference beneficiaries of the deceased: (1) widow or widower; (2) children: (3) parents; (4) brothers or sisters; (5) executor or administrator.
The undersigned, for himself/herself, their heirs, executors, and assignees hereby agree to release and forever discharge the Company from any further liability under the above-referenced policies and further agree to indemnify the Company and to hold harmless from any and all claims, costs, expenses and damages which may result from the Company's reliance on the representations made herein and payment in accordance therewith.

State or Province of _____ County of _____ SS # _____

I, _____ residing at _____

_____ (City or Town) , _____ (State or Province) , being first duly sworn, depose, and state:

**WIDOW OR WIDOWER**

That I am the surviving spouse of the deceased person named above.

The date of my birth is _____ / _____ / _____ Signed X _____

**SON OR DAUGHTER**

That the deceased person named above left no surviving spouse; that I am the child of the deceased; and that the deceased left no surviving children other than myself and those listed below:

| NAME | ADDRESS | SS# | DATE OF BIRTH |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

The date of my birth is _____ / _____ / _____ Signed X _____

**FATHER OR MOTHER**

That the deceased person named above left no surviving spouse or child; that I am a parent of the deceased; and that the other parent is listed below:

| NAME | ADDRESS | SS# | DATE OF BIRTH |
|---|---|---|---|
| | | | |

The date of my birth is _____ / _____ / _____ Signed X _____

**BROTHER OR SISTER**

That the deceased person named above left no surviving spouse, child, or parent; that I am the brother/sister of the deceased; and that the deceased left no surviving brothers or sisters other than myself and those listed below:

| NAME | ADDRESS | SS# | DATE OF BIRTH |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

The date of my birth is _____ / _____ / _____ Signed X _____

**EXECUTOR OR ADMINISTTRATOR**

That the deceased person named above left no surviving spouse, child, parent, or brother/sister; that I am the executor or administrator of the estate of the deceased.

Signed X_____

Subscribed and sworn to before me this _____day of _____ , 20_____

(SEAL) _____
Notary Public or other official authorized to administer oaths

My commission expires _____

# AMERICORPS PROGRAM DATA FORM

## Health Care Plan for AmeriCorps

Please complete this form and fax to SRC at (803) 865-3787

PLEASE PRINT LEGIBLY OR TYPE ALL REQUIRED INFORMATION

### PART A—GRANTEE INFORMATION

| Program's Name | Program Director's Name: | E-Mail Address: | Effective Date of Grant |
|---|---|---|---|
| Grantee's Name | Program Health Care Contact | | Program year MM/DD/YY From _____ to MM/DD/YY _____ |
| Grant Number | Phone Number ( ) | | Fax Number ( ) |
| Street Address | City, State, & Zip Code | | Number of Full-Time To Be Enrolled: / Number of Part-Time To Be Enrolled: |

### PART B—BILLING INFORMATION

| Billing Contact Name: | Billing Mailing Address (City, State, & Zip Code): | |
|---|---|---|
| Phone Number: ( ) | Fax Number: ( ) | E-Mail Address: |

### PART C—REPORTING INFORMATION

1. Plan elected (check one): CNA Option I ☐ or CNA Option II ☐
2. Is your program affiliated with: ☐ State/ ☐ National / ☐ Tribes & Territories / ☐ Learn-n-Serve?
3. Your Executive Director's Name_____ Phone Number_____ Fax Number _____ (required information)
4. Will Part-Time members be enrolled? ☐ Yes / ☐ No (If "No," go to Question #5)?
5. If "Yes," please indicate method of payment: ☐ Payroll Deduction / ☐ Paid by Program / ☐ Other (please explain)
6. Have you received your Grant Funding? ☐ Yes / ☐ No?
7. Do you have sub grantees that will need administrative manuals or materials? ☐ Yes / ☐ No (If "Yes," complete #8)?
8. Do you have sub grantees that will submit rosters and pay their own invoices? ☐ Yes / ☐ No (If "Yes," complete #8)?
9. Complete the information below if you answered "Yes to #6 or #7.

| Name of Program | Check One: Sub Group | Subgrantee | Mailing Address | City, State, Zip | Telephone | Fax | Contact |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

### FAX INFORMATION

Fax #: **(803) 865-3787** Date: _____

To: **SRC/AmeriCorps** Of: **SRC (803) 865-3737 – Phone**

From: _____ Of: _____

| For SRC Office Use Only | |
|---|---|
| Assigned Program Number | |
| Funding | |
| Date Received | |