



AmeriCorps NCCC

Health Benefit Plan Member Guide

Want
to better
understand
your
healthcare
program?

The information in this
guide is designed to help.



Identification Card

As an AmeriCorps NCCC member you will receive an identification card to be used as proof of healthcare coverage when you need medical or prescription services. Simply show your identification card to the pharmacy, hospital, physician or provider at the time of service. If you have other insurance you must present both cards at the time of service to ensure that the provider bills both your primary plan as well as IMG as the administrator of your plan with AmeriCorps NCCC. Failing to present all cards may delay the claims processing.

You should carry your identification card with you at all times in case you need emergency treatment. The back of your identification card contains important information regarding procedures and the address used to file claims.

Lost or misplaced cards can be replaced as follows:

- A virtual ID card can be downloaded by you online through **<https://americorpsnccc.imglobal.com>**.
- You can request an ID card via email to **NCCCcare@imglobal.com** and one will be emailed to you within 1 business day.
- You can call IMG at **855-851-2974 or 317-833-1711**.

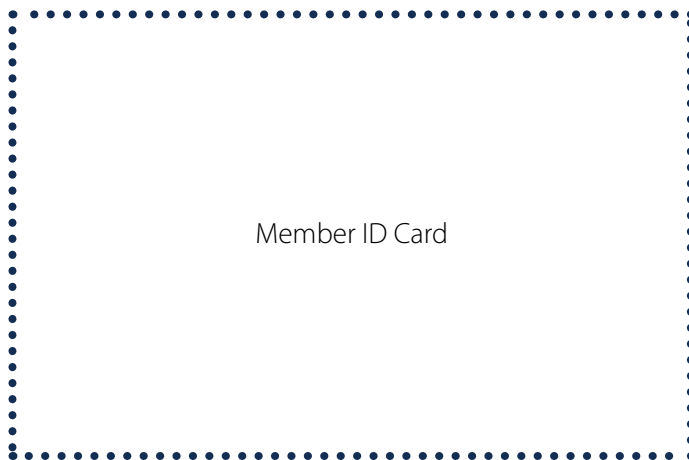


Table of Contents

Identification Card	2
Introduction	4
Coverage	5
Medical Exclusions	9
PPO, Telehealth, & Pharmacy Resources	12
Pharmacy Exclusions	15
Administration	16
Coordination of Benefits	17
Customer Care	19
Plan Definitions	20

1. Introduction

Eligibility

Thank you for your service to America's communities in need through the AmeriCorps program. As an AmeriCorps NCCC member, you are eligible to participate in the Health Benefit Plan. The **AmeriCorps NCCC Health Benefit Plan** is provided at no cost automatically upon your entry into training or service, and will terminate automatically on the date your AmeriCorps service ends.

The content in this guide is intended to provide an overview of the **AmeriCorps NCCC Health Benefit Plan** as well as how to use your benefits for covered medical expenses.

The **AmeriCorps NCCC Health Benefit Plan** is a self-funded health benefit plan created by AmeriCorps and paid for with funds appropriated by Congress. This is a limited healthcare plan administered by International Medical Group, Inc. (IMG®); **this is not an insurance policy.**

International Medical Group, Inc. (IMG®) provides all general administration and oversight of all of the healthcare services including Enrollment, Customer Service, Claims Payment, Financial Management, Utilization Management, Preferred Provider Network (PPO) accessibility through the First Health Network, Pharmacy Services through Universal RX, and telehealth options through Teladoc. Please open and review all information sent to you from IMG, First Health, Universal RX or Teladoc.

Upon request, material will be made available in Spanish and alternative formats for people with disabilities.

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

2. Coverage

See below for a chart of covered benefits.

Type of Coverage	Definition	Coverage Limits / Copays / Deductibles
Emergency Services	The plan covers emergency outpatient services for injuries resulting from an accident, including an automobile accident and emergency illness.	
Ambulance	Professional ambulance service to the nearest hospital where you can be treated or to another hospital in the area if necessary treatment is not available at the nearest hospital. Ambulance service from the hospital to the member's home, only if medically necessary.	
Inpatient Hospitalization Services	<p>If you are confined to a hospital, the health plan will pay hospital charges for the services listed below which are not related to pre-existing conditions: charges incurred for operating, recovery, delivery, labor, intensive care, coronary care and cystoscopic room.</p> <p>Room and board, general nursing care, meals and dietary services provided by the hospital are covered for a semiprivate room or ward accommodations. If a private room is medically necessary, the plan will cover the cost.</p>	<p>If you are hospitalized prior to your service termination date and the hospitalization continues past the termination date, medical expenses for the duration of the hospitalization will not be covered under this health plan.</p> <p>For room and board coverage, the plan provides care up to 21 days per a members service term and no more than 60 days per lifetime of service. The annual maximum of 21 days of inpatient room and board can be used for mental health treatment and for alcohol or substance abuse for detoxification in a hospital or licensed in-hospital detoxification facility. Outpatient treatment of alcohol or substance abuse is not covered.</p>
Facility Expenses	Charges associated with operating, recovery, delivery, labor, intensive care, coronary care and cystoscopic rooms.	
Surgical Care	AmeriCorps pays for surgical expenses whether on an inpatient or outpatient basis. Surgical expenses include usual pre-operative and post-operative care for treatment of a disease, injury or ailment; cutting or incision; and/or suturing of wounds; treatment of fractures and dislocated bones; and endoscopic procedures where a tube is inserted to examine internal organs or for the treatment of fractured and dislocated bones.	
Anesthesia	General anesthesia, spinal anesthesia, and epidurals are covered when administered by an anesthesiologist. Other anesthesia, including conscious sedation, may be administered by the attending physician, dentist or registered nurse as dictated by hospital or facility policy.	

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

Type of Coverage	Definition	Coverage Limits / Copays / Deductibles
Maternity Services	<p>Covered maternity services include prenatal care, routine labs/screenings according to the standards of care of the ACOG (American Congress of Obstetricians and Gynecologists), delivery of the child, hospitalization and treatment of the mother relating to the delivery of the child to include any complications affecting the mother. Benefits will be paid for all covered services provided by a certified nurse midwife who is a licensed registered nurse and certified as a nurse midwife by the American College of Nurse Midwives or meets other requirements as mandated by law.</p> <p>Nursery Care Services are provided and include routine care for the newborn while the mother is hospitalized for covered maternity care; complications affecting the infant are not covered.</p>	<p>Coverage is only available while you are in active service.</p> <p>A member who is pregnant during their service may continue their service provided they can continue to perform full-time duties. If the member wishes to remain in service beyond the delivery date, the member must have sufficient leave available for recuperation after giving birth. For more information for allowable leave, please contact your unit leader or Member Support Specialist.</p> <p>Health benefits do not extend to dependents of members.</p>
Mental Health	<p>Inpatient Mental Health care: The plan covers mental health care for inpatient hospital services subject to the preexisting condition exclusion.</p> <p>Outpatient Mental Health care: When outpatient mental health care is provided by a physician, a psychiatrist, a licensed clinical psychologist or a master of social work.</p>	<p>Outpatient mental health visits are not subject to limitations on pre-existing conditions.</p>
Preventive Care	<p>The benefit pays for only the following preventative / routine care services:</p> <p>For female members:</p> <ol style="list-style-type: none"> 1. One GYN health visit per service year that includes one pelvic examination, Pap smear and breast examination when performed at the time of the annual GYN health visit. 2. Contraceptive management. Oral contraceptives, diaphragms, IUDs and contraceptive injections when prescribed by a medical doctor. 3. One mammogram for women over 40 is covered per service year. All other routine mammograms are not included as part of these services. 4. One Bone Mineral Density test (BMD) for women. <p>For males over 50: One prostate examination, including a PSA, is covered by the plan per service year.</p> <p>STD testing is covered for all members</p>	<p>You will be responsible for a \$5.00 copay for each medical office visit. This charge will be expected to be paid at the time of your visit and will be deducted from the total cost of the services.</p>
Immunizations	<p>Those immunizations recommended by the United States Center for Disease Control.</p>	<p>Immunizations required for travel outside of the United States are not covered.</p> <p>Flu vaccinations are covered at 100%. HPV vaccines are covered at 100% up to age 26.</p>
Laboratory Tests and X-Rays	<p>Services are covered if recommended or performed by a licensed provider for diagnostic purposes due to symptoms, illness or injury.</p>	<p>Covered at 100%. Routine testing is not covered.</p>

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

Type of Coverage	Definition	Coverage Limits / Copays / Deductibles
Professional Services	Services provided by a physician for the treatment of a medical condition in a hospital, physician's office, or your home. The plan pays up to the usual, customary and reasonable charges for these types of services. Consultation services are covered if a second surgical opinion is needed to confirm your diagnosis or treatment. Approved providers of service include Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgeries (DDS or DMD), Psychologist (PhD) and any other provider licensed in the state where services are provided. Special nursing services by actively practicing nurse practitioners, registered nurses, licensed practical nurses and licensed vocational nurses, as prescribed by a physician, are also included.	You will be responsible for a \$5.00 copay for each medical office visit. This charge will be expected to be paid at the time of your visit and will be deducted from the total cost of the services. Copay is waived for services provided by Teladoc.
Pharmacy	Your plan covers prescription drugs (brand and generic) at retail locations and through mail order that are prescribed by your provider subject to the exclusions and limitations of the plan.	\$0 copay for generic medication. \$5 copay for brand name medication with a generic equivalent. \$0 copay for brand name medication without a generic equivalent. See pharmacy exclusions in the exclusion section of the guide for a full description of things that are not covered.
Dental	Dental services necessary for the performance of a surgical service to correct non-chewing accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth as well as x-rays, teeth, supporting bone and tissue that occur while the member is covered under this contract including x-rays as the result of an accidental bodily injury. Emergency dental services covering care which must be provided immediately for the relief of pain and the correction of the disorder causing the pain.	Emergency services covered may include treatment of abscesses, root canals and extractions, but will not include cleaning, crowns, dentures, routine fillings or the routine removal of wisdom teeth.
Vision	Charges for an eye examination, replacement of eyeglasses or contact lenses lost or damaged in the line of duty subject to the schedule at the right:	<ul style="list-style-type: none"> • Replacement/repair of frames and lenses (combined) \$50. • Eye examination for eyeglass replacement \$25. • Replacement of contact lenses \$50. • Eye examination for contact lens or lens replacement \$25. • NOTE: Services related to the treatment of eye disease or eye injury are covered, subject to the pre-existing condition limitation.
Artificial Limbs or Eyes	Prosthetic appliances and orthopedic braces for disabilities arising during service, and the repair of such appliances and their replacement when medically necessary.	
Blood	Blood, blood plasma or blood expanders when not donated or replaced.	

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

Type of Coverage	Definition	Coverage Limits / Copays / Deductibles
Diabetic Supplies	Insulin, lancets, alcohol swabs, glucometers, test strips, disposable needles and syringes only.	
Equipment	Includes casts, splints, trusses, braces, crutches or surgical dressings	
Equipment Rental (Durable Medical Equipment)	Includes rental or purchase (whichever is less) of durable medical equipment deemed necessary for therapeutic use including crutches, wheel chair, hospital bed and oxygen and rental of equipment for its administration.	Physician's order is required for DME to be considered for payment.
Hearing Device Repair	Repair of hearing aid when device is broken or lost in the line of duty.	
Speech Therapy	Services covered when provided by a physician or by a licensed speech therapist when prescribed by a physician.	
Physical Therapy	Services covered when provided by a physician or by a licensed physical therapist when prescribed by a physician.	
Phototherapy	Services covered when provided by a physician or by a licensed phototherapy nurse when prescribed by a physician. Note: tanning / tanning salons are not covered.	
Hemodialysis	Services provided by a freestanding hemodialysis center (except in the case of Chronic Renal Failure and End Stage Renal Disease).	
Radiation Therapy	Radiation and chemotherapy including treatment of disease by chemical, biological antineoplastic agents, x-rays, radium or radioactive isotopes.	
Occupational Therapy	Services covered when provided by a physician or by a licensed occupational therapist when prescribed by a physician.	
Ostomy Supplies	When prescribed by a physician.	

Pre-Existing Conditions

All covered services are subject to the pre-existing condition clause. **AmeriCorps NCCC does not provide coverage for any diagnosis that is considered a pre-existing condition.** A pre-existing condition is defined as any condition or illness for which medical treatment was given, or a diagnosis was made, on or before your start of service.

If a claim is submitted that appears to be a pre-existing illness or condition, it will not be paid until additional information is provided to confirm the onset of the condition occurred after you joined service.

Exceptions: Outpatient Mental Health Conditions and Pregnancy are not considered pre-existing conditions on this plan. If you are medically terminated and reinstated at a later date, the health plan will cover you for the condition for which you were medically terminated. Pregnancy is not subject to the pre-existing condition clause. If you re-enter service with AmeriCorps NCCC within 180 days of the termination of the termination of your previous service, those medical conditions covered during your previous service term will be covered during the new term of service and not considered pre-existing. However, newly diagnosed illness injuries incurred during the gap in service will be considered pre-existing conditions.

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

Plan CoPay

You will be responsible for a copay of \$5.00 for each medical office visit. This charge will be expected to be paid at the time of your visit and will be deducted from the total cost of the services. No copay will be charged for inpatient services. There is no copay for Telehealth services provided by Teladoc.

3. Medical Exclusions

- **Abortion or Sterilization Surgery**
- **Acupuncture Therapy**
- **Alcohol, Drug Abuse or Detoxification Treatment** - For services beyond what is covered under hospital coverage.
- **Allergy Tests or Injections** - Any services related to the treatment of allergies including allergy tests and surveys, injection, medication and treatment (except for emergency treatment including medication and hospitalization for asthma).
- **Biofeedback Therapy**
- **Cardiac Rehabilitation Services**
- **Chiropractic Services**
- **Congenital Anomalies**
- **Contraceptives** - Charges for non-prescription contraceptives.
- **Cosmetic Surgery** - Any services performed in connection with cosmetic surgery (except for conditions required for the repair of accidental injury suffered while the member is enrolled) for a non-functional condition or for any condition that existed on the effective date of the member's coverage.
- **Counseling** - Charges for or in connection with counseling services of the following types: marriage, partner, relationship, family, child, career, social adjustment, pastoral or financial. Exception: See Mental Health Services under Covered Services within the Benefits Schedule.
- **Dental** - Dental coverage does not cover routine dental care including cleaning, crowns, dentures, routine fillings or the routine removal of wisdom teeth.
- **Equipment (DME)** - Purchase or rental of equipment such as air conditioners, humidifiers, purifiers or similar devices.
- **Experimental Procedures** - Any treatment or supplies which are experimental or unproven by scientific evidence or generally not accepted by informed health care professionals as effective in treating the condition, diagnosis or illness for which their use is proposed.
- **Feet** - any illness or treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; this does not apply to infections of the toenails or feet and does not apply to casts, splints or braces for treatment of injuries.
- **Genetic Testing** - Unless testing is covered under Pregnancy Covered Services.
- **Hemodialysis** - For Chronic Renal Failure and End Stage Renal Disease not related to an acute episode requiring Hemodialysis.

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

- **Home Health** - Unless a covered inpatient service is less expensive when administered at home.
- **Hospital Care** - When primarily for diagnostic purposes (unless the condition or type of tests require hospitalization), convalescent or custodial care (unless in conjunction with regular hospital confinement within the previous seven days), institutional care, rest or rehabilitation. Also hospitalization primarily for physical therapy or occupational therapy, unless the therapy could not have been provided on an outpatient basis and the complexity of the member's condition required additional skilled care.
- **Immunizations** - Required for travel outside of the United States
- **Newborn** - Complications affecting the infant.
- **Nursing** - Private duty nursing care or services of special nurses and payment for their meals.
- **Obesity or Weight Reduction Treatment**
- **Orthopedics** - Shoes or other supportive devices for the feet.
- **Physicals** - Care provided as part of an annual or routine physical examination including routine lab work.
 - Exceptions:
 - See Preventative Care under Covered Services.
- **Preconception Services or Supplies** - For the purpose of inducing pregnancy, such as "in vitro" (test tube) fertilization, artificial insemination or experimental services.
- **Pre-existing Conditions** - **Benefits are not paid for services in connection to pre-existing conditions. A pre-existing condition is any condition or illness for which medical treatment was given, or a diagnosis was made, on or before the start of service in the AmeriCorps NCCC program. Outpatient Mental Health Conditions and Pregnancy are not considered pre-existing conditions on this plan.**
- **Personal Comfort Items** - Any personal comfort item (purchased or rented) such as a telephone, television beauty services.
- **Services or Supplies:**
 - Which are not medically necessary for the diagnosis or treatment of an illness
 - Provided by a member's spouse, parent, sibling or child
 - Filed for payment later than two years from the date the services were provided
 - Which would not have been incurred if the patient did not have this coverage
 - Eligible for payment under worker's compensation benefits
 - Related to a military service disability or other condition resulting from war
 - Provided in an extended care facility
 - For room or board in an institution that is not a hospital
 - When benefits are available under a personal injury protection contract
 - No-fault motor vehicle insurance
 - Any private group health insurance plan
 - As a result of subrogation from liable third parties.
- **Sexual Transformations, Sexual Impairment or Inadequacy Treatment**
- **Skilled Nursing/Extended Care** (Unless a covered service is less expensive when administered under skilled nursing or extended care.)
- **Surgery** - Services that are not medically necessary.
- **Temporomandibular joint Disease (TMJ)** - Medical or dental services or supplies for the treatment of TMJ.

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

- **Transplant, tissue or solid organ** - Services or supplies for or related to any tissue or solid organ surgical transplants and any complications resulting from any such procedures including, but not limited to, heart, lung, kidney, pancreas, cornea, liver, bone marrow, (autologous or allogeneic for any diagnosis), skin graft and bone grafts. Related services or supplies including, but not limited to, administration of high dose chemotherapy, radiation therapy, or any other form of therapy, or immunosuppressive drugs are not covered when associated with any tissue or solid organ transplant procedure.
- **Transportation** - Other than covered ambulance service.
- **Vision** - Services or supplies for the medical or surgical treatment of myopia (nearsightedness) or hyperopia (farsightedness) including, but not limited to, radial keratotomy and the other forms of refractive keratoplasty, including laser surgery.

Benefits are subject to exclusions and limitations and are payable only at Usual, Reasonable, and Customary charges. This is a summary of a selection of plan benefits offered only as an illustration and does not supersede in any way the Certificate of Insurance or the Application, Master Policy and any riders or other governing documents (the "Insurance Contract"). The Insurance Contract is the only source of the actual benefits provided.

4. PPO, Telehealth, & Pharmacy Resources

PPO

The primary PPO network for the AmeriCorps NCCC Health Benefit Plan is the First Health Provider Network. The logo for the First Health Medical Network is on the front of your benefit card. You must present this card and any other benefit and insurance cards to your provider at the time of service. **When contacting a provider in the First Health Network it is important to say: "My healthcare plan utilizes the First Health Network."**



Using a PPO provider saves you money because AmeriCorps will pay 100% of the covered charges (or up to the policy limit). In most states, payment will not be required at the time of services (except for the co-pay amount).

Failure to use an available PPO provider in a network area will result in your being responsible for charges over the usual and customary amount. This means you will be responsible for any costs not paid by the healthcare plan, and providers may require payment at the time of service.

If you contact a network provider that denies participation in the First Health Network, please contact IMG immediately with the provider name, phone number and address. Please note that appointment availability is based on a physician's schedule. If a provider is not accepting new patients, you will need to contact a different provider.

35 Mile Exemption

If your home address or SPIKE location is over 35 miles from the nearest medical network provider, you are exempt from the provider network guideline. You will not be penalized when receiving care from an out-of-network provider; however, you will need to call IMG Customer Care to coordinate this exemption.

Telehealth



Teladoc Telehealth is a non-insurance benefit that provides access to board certified physicians, psychologists, social workers and professional counselors 24/7 via phone or video chat. It is a faster and often easier method of seeking doctor's advice than a visit to urgent care or the ER or seeking a mental healthcare provider.

The team of qualified and credentialed medical professionals can consult, council, diagnose, and prescribe medications directly to your pharmacy if necessary.* Some of the most common uses include: cold and flu, sinus infections, allergies, urinary tract infections, pink eye, and many more.

2 Ways to Connect with a Telehealth Provider

1. You can connect to Teladoc by visiting americorpsnccc.imglobal.com and clicking the **"Connect with a Telehealth Provider Now" button on the homepage**. This is the fastest and easiest way to see a telehealth provider immediately.



2. You can also connect to Teladoc by calling **1-800-Teladoc (1-800-835-2362)**. When calling, please be sure to mention that you are an AmeriCorps NCCC member.

How to file a claim

Claims will be submitted directly to IMG by Teladoc. If additional information is needed you may be contacted by a service representative from IMG.

If you are experiencing a crisis or emergency, call 911 or go to your nearest emergency room. You can also access the free, 24-hour National Suicide Prevention Lifeline at 1-800-273-8255.

***Prescriptions are written when deemed medically appropriate. No DEA controlled substances, antipsychotics, or lifestyle drugs will be prescribed. Coverage is only available while you are in active service. \$0 copay for telehealth visits.**

Pharmacy



Universal Rx is a non-insurance benefit that provides prescription drug plan administration. Through their nationwide network community and chain pharmacies, and their mail-service pharmacy option, you have the broadest choice of pharmacies to choose from to satisfy your prescription drug needs. The Universal Rx network of pharmacies includes over 60,000 pharmacy locations nationwide. To find a participating pharmacy, go to the website <https://americorpsnccc.imglobal.com> or call the URX Pharmacy Help Desk at 800-800-7364.

Pharmacy Fills and Payment

You will have one healthcare identification card containing all of the information required by your medical care provider and/or pharmacy. Simply present your card to have your prescriptions filled at any one of the network pharmacies in your area. The pharmacy will then electronically transmit a claim for that medication and within minutes have approval for filling the prescription.

You may obtain up to a one-month supply of your prescription medication from a retail network pharmacy and up to a three-month supply through the Universal Rx Direct Mail Service.

Your health plan encourages all maintenance medications or medications taken on an ongoing basis must be purchased through the Direct Mail Service. You may obtain information regarding online ordering via a link at <https://americorpsnccc.imglobal.com>.

In the unlikely event a pharmacy in your area is not part of our network then please ask your pharmacist to request a participation agreement by calling the Universal Rx Network Service Department at 800-800-7364.

Brand versus Generic Drugs

You can help lower your cost, and the cost AmeriCorps pays each year for medications, by using generics whenever possible. When you need a new prescription, ask your doctor whether a generic can be substituted for a brand name. You can also ask your pharmacist. In many cases they can substitute a generic for the brand without further approval. In some cases your pharmacist may need your doctor's permission.

There is a **\$5 copay for brand drugs** when there is a generic available. There is **NO COPAY** for generic drugs.

Mail Service

Mail-Service pharmacy provides a convenient way for you to have your medication delivered right to your home or office. Universal Rx Direct Mail Service should be the first choice for people using maintenance medications. These are medications taken on an ongoing basis such as asthma, heart and cardiovascular conditions, diabetes and even oral contraceptive medications. And with mail-service you are authorized 90-day supplies of your medications at each fill.

To start using mail-service you'll need a prescription from your doctor for each medication. Ask your doctor to authorize a 90-day supply and four refills. Be sure to also obtain a prescription for an initial fill at your local pharmacy if you need to use the medication right away or don't have existing supplies of your medications.

Requests for reimbursement of pharmacy prescriptions require completion of the Prescription Claim Form, which is located online at <https://americorpsnccc.imglobal.com>.

5. Pharmacy Exclusions

- Any over-the-counter drug that can be bought without a prescription
- Therapeutic devices or appliances or other non-medical substances, regardless of their intended use.
- Nonprescription contraceptives and supplies related to birth control, injectable and implantable contraception, with the exception of birth control pills and diaphragms which are covered.
- Drugs used to deter smoking
- Anorexiant, anti-obesity drugs
- Any drug for cosmetic purposes, including, but not limited to, Rogaine.
- Any quantity of drugs dispensed which exceeds the supply and refill limits
- Any prescription or refill dispensed more than one year after the original prescription
- Prescriptions filled prior to the effective date or after the termination date of the member's coverage
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs which are experimental or investigational in nature, or which are in connection with experimental or investigative services or supplies, including drugs requiring federal or other governmental agency approval not granted at the time they are prescribed
- Related services or supplies including, but not limited to, administration of high dose chemotherapy, radiation therapy, or any other form of therapy, or immunosuppressive drugs are not covered when associated with any tissue or solid organ transplant procedure
- Immunization agents
- Biological sera
- Unreceipted blood, blood plasma or blood expanders.
- Drugs for the treatment of MS, including, but not limited to, Betaseron, Avonex, Copaxone, Tysabri, Rebif, Interferon
- Fertility drugs
- Fluoride preparations
- AIDS-related drugs
- Non-insulin syringes/needles
- Vitamins, vitamin A derivatives
- Human growth hormones
- All drugs related to Erectile Dysfunction (ED)

6. Administration

Medical Claims Payment

Claims are automatically submitted to IMG for you when you use a provider within the First Health PPO network or Teladoc and present your ID card to the provider. You will not be responsible for charges (except for your copayment, if there is one) over the usual, customary and reasonable charges.

If you have a claim from a non-PPO network provider or receive a claim from a provider, you will need to complete a claim form and attach all of the itemized original bills needed to support processing and payment of your claim. Claims must be filed for reimbursement no later than two years from the date the services were provided.

To get a Health Benefit Plan Claim Form, go to <https://americorpsnccc.imglobal.com>. The Health Benefit Plan Claim Form is a fillable form and you can complete it and email it to NCCCcare@imglobal.com with a scanned copy of all of the applicable receipts or upload directly from your MyIMGNCCC account for which you are requesting reimbursement.

If you prefer to complete a paper form, you can download one or call customer service and request one. You can print and mail it to the address on the back of your identification card if you prefer not to submit the information via email.

Itemized original bills must be submitted to verify the information we need to process your claim. Canceled checks are not acceptable proof of a claim. Bills do not need to be marked paid before you can claim your benefits. Original bills submitted will not be returned so ensure you keep a photocopy of all bills and receipts for your personal records. The bills you submit must include the following information:

- a) Name, address and professional status of the person or organization providing the service
- b) Provider Tax ID number
- c) Name of patient receiving service (member name)
- d) Date of service
- e) Description of each service
- f) Diagnosis
- g) Charge for each service
- h) For eligible psychotherapy expenses, include the length of each session and session type (ex., group or individual)

Decisions regarding the payment of a claim are generally made within two to three weeks after receiving a claim. In special situations, additional time may be needed to make benefit determinations regarding your claim. If a benefit determination decision is delayed for more than 90 days, a notice will be sent to you explaining the reason for delay.

If a claim is paid to your provider, they receive a check and an explanation of benefits. An explanation of benefits tells them what your plan pays or doesn't pay. If any claim or portion of a claim is denied, you and your provider will receive an explanation of the denial. You may request further explanation or provide additional information to be considered regarding your claim.

7. Coordination of Benefits

AmeriCorps NCCC Health Benefit Plan participants have a Coordination of Benefits provision within this plan.

The Coordination of Benefits provision determines which plan is the primary payer and must pay claims up to the limit of its plan. The other plan is then designated as the secondary payer and must pay any of the remaining covered amounts. At no time is the combined payment greater than the billed amount.

The AmeriCorps NCCC Health Benefit Plan is secondary to all insurance with the exception of Medicare, Medicaid and Military Benefits.

If you have health care coverage other than this **AmeriCorps NCCC Health Benefit Plan**, present both ID Cards to each provider and explain to use the following guidelines to determine when claims should be submitted to the plan administrator (IMG®) as the primary payer:

1. Do you have other health insurance coverage? If yes;

1st: Submit claims to private insurance carrier; then

2nd: Submit remaining charges identified via an Explanation of Benefits (EOB) to the AmeriCorps NCCC Health Benefit Plan using the claim submission information on the back of your ID card.

2. Do you have Medicare, Medicaid, or Military benefits? If yes;

1st: Submit charges first to the AmeriCorps NCCC Health Benefit Plan; then

2nd: Submit remaining charges to Medicare, Medicaid or your Military benefits plan with the IMG EOB.

When you have a medical claim and it has been paid or denied, there is an explanation of benefits created. IMG makes all of your explanation of benefits available to you through the secure area of the AmeriCorps NCCC website accessible at <https://americorpsnccc.imgglobal.com>.

Precertification

All inpatient hospital stays, including detoxification facilities, must be precertified. If a network hospital is in your area, you should make every attempt to utilize that facility. A \$300 penalty will be applied if precertification is not obtained prior to hospitalization. The member is responsible for paying all applicable penalties.

If you are getting ready to schedule a medical service or procedure where you will have to be admitted as an inpatient to a hospital, either you or the provider's office handling your care can initiate a precertification online at

<https://americorpsnccc.imgglobal.com> or by calling toll free 855-851-2974 or 317-833-1711.

Precertification hours are 9:00 a.m. to 8:00 p.m. EST Monday through Friday; you may leave a secure message after hours that will be returned during the next business day.

Once the precertification has taken place, IMG will notify you, your provider, and the hospital in writing within 24 hours of the precertification decision and the approved number of hospital days. If your hospital admission has been precertified, and your confinement requires additional hospital days, IMG nursing staff will review the information provided and determine if additional hospital days are medically necessary. If an extension cannot be approved, a physician advisor will review your case, discuss your ongoing admission with your provider, and render a decision.

Note: Precertification is not a guarantee of payment, but a process to document medical necessity. Precertification approval does not mean coverage approval. Coverage approval is based on the terms and conditions described in this guide.

Right to Appeal

A General Medical or Pharmacy Claim Decision Appeal

If you do not agree with how a claim was paid, you or your authorized representative may appeal a denial of benefits for any claim or portion of a claim by sending your appeal and any additional information related to the claim and comments in writing to IMG. Upon receipt of your written appeal, IMG will review the information and if necessary may request additional information to assist in making a fair determination. The appeal decision should be returned to you within 90 days.

A Precertification Decision Appeal

If you or your physician do not agree with the precertification decision, you have the right to appeal. The appeal process is available for continued stay requests or for future admissions or procedures. The appeal may be initiated by you, your attending physician, or the utilization review staff of the facility where the service is performed.

The appeal can be initiated by contacting IMG by telephone, fax or secure email. The right to the appeals process will be offered to the member or his/ her authorized representative, provider, or the facility rendering service at the time of non-certification for the requested level of care. The appeals process must be initiated within 180 calendar days after the receipt of the non-certification notification. A copy of the full IMG appeals policy is available upon request of the member or his/her authorized representative, provider or treating facility and is available on <https://americorpsnccc.imglobal.com>. Responses to appeals will be made within 30 days after all information has been received.

8. Customer Care

Customer Care business hours are **9:00 a.m. to 8:00 p.m. EST Monday through Friday**. If you call after hours, you can leave a non-emergency secure message and a representative will call you back within 1 business day.

AmeriCorps has contracted with IMG to help you answer any questions, concerns, or requests you may have regarding your AmeriCorps NCCC Health Benefit Plan. You can contact IMG Customer Care in any of the following ways:

1. Go on-line to the IMG / AmeriCorps NCCC Healthcare Website – <https://americorpsnccc.imglobal.com>

The website is designed for members to find information regarding the AmeriCorps NCCC Health Benefit Plan quickly and easily. You may access the following information at <https://americorpsnccc.imglobal.com>:

- Find doctors, hospitals, pharmacies and other providers in your network
- Print necessary forms or complete them electronically
- Review the guide electronically
- Access customer service in a secure manner to ask questions about personal and private healthcare information
- Create your MyIMG NCCC member portal account to be able to obtain an electronic version of your ID card, review results of claims, or submit claims online anytime.
- Initiate a chat session
- Review Frequently Asked Questions (FAQ's)

2. Call IMG Toll Free at 855-851-2974 or 317-833-1711

3. Email IMG at NCCCcare@imglobal.com

4. Write IMG:

**IMG / AmeriCorps
Attn: Customer Service
P.O. Box 550, Farmington Hills, MI 48332**

9. Plan Definitions

Approved Providers of Service - When you are ill or injured, your coverage helps pay the hospital and your physician as well as appropriate charges for other approved health care professionals. These providers include but are not limited to:

Hospital – any hospital accredited by the Joint Commission on the Accreditation for Health Organizations, including Veterans Administration Hospitals and Department of Defense Hospitals.

Physicians – any provider licensed in the state where the services were provided. These include: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgeries (DDS or DMD), Podiatrist (POD) and Psychologist (Ph.D.).

Other Providers – Nurse anesthetist, nurse practitioner, psychiatric social worker, respiratory therapist, speech therapist, occupational therapist, optician, optometrist, physicians' assistant, private duty nurse, technical surgical assistant, registered physical therapist or physiotherapist. All of the above mentioned providers must be licensed or certified in the jurisdiction where the services were provided.

Benefit Year - The one-year period that begins on your start date in the AmeriCorps NCCC program and ends on your last date of service in that term. You accumulate your benefits in this period of time.

Certified Nurse Midwife – Must be a licensed registered nurse and certified as a nurse midwife by the American College of Nurse Midwives.

Copay - The amount the member is responsible to pay for each medical office visit or prescription.

Covered Charges - Charges that are not excessive for covered services. Judgment will be based on one or a combination of the following: a negotiated rate based on services provided; a fixed rate per day; or the usual, customary and reasonable allowance for similar providers who perform like covered services.

Covered Services - Services or supplies for which benefits will be paid when provided by a provider acting within the scope of his/her/its license. In order to be considered a covered service, charges must be incurred while your coverage is in force.

Exclusions - Any service or supply related to pre-existing conditions or other conditions specifically not covered under this plan.

Experimental - Any treatment, procedure, facility, equipment, drug, device or supply which:

1. Is not accepted as standard medical treatment for the condition being treated; or
2. Requires but has not received federal or other governmental agency approval at the time of service.

Identification Card - A card issued by the administrator of the plan (IMG) that bears the member's name, identifies the membership by number and may contain information about his or her coverage.

Medically Necessary or Medical Necessity – Services or supplies, provided by a provider facility or an individual provider, which are required for treatment of illness, injury, diseased condition or impairment and are:

1. Consistent with your diagnosis or symptoms;
2. Appropriate treatment, according to generally accepted standards of medical practice;

3. Not provided only as a convenience to you or to the provider;
4. Not experimental or unproven; and
5. Not excessive in scope, duration or intensity to provide safe, adequate and appropriate treatment. Any service or supply provided at a provider facility will not be considered medically necessary if your symptoms or condition indicates that it would be safe to provide the service or supply in a less comprehensive setting.

Medicaid - The program of health care for qualifying people who cannot finance their own medical expenses established by Title XIX of the Social Security Act of 1965, as amended.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Outpatient - An insured who is a patient, other than a bed patient, at a provider facility.

Preferred Provider - Providers of service who have been selected or have decided to become part of a preferred network to work with an insurer to help control costs to patients.

Pre-Existing Condition - A pre-existing condition is any condition or illness for which medical treatment was given, or a diagnosis was made, on or before the member's start of service in the AmeriCorps NCCC program.

Exception: Outpatient Mental Health Conditions and Pregnancy are not considered pre-existing conditions on this plan. All members who are medically terminated and reinstated within 180 days will have the condition for which they were medically terminated covered by the health plan.

Spike - Assignment to projects away from your AmeriCorps NCCC and FEMA regional campus.

Usual, Customary and Reasonable (UCR) - A typical and reasonable amount of reimbursement for similar services, medicines, or supplies within the area in which the charge is incurred. In determining the typical and reasonable amount of reimbursement, one or more of the following factors may be considered: the amount charged by the provider; the amount charged by similar providers or providers in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in the same or similar locality. When covered charges are based on the UCR allowance, the AmeriCorps NCCC Health Benefit Plan will pay the UCR allowance or billed charges, whichever is less.

BE
There







Thank you for your service to
America's communities in need!



AmeriCorps

P.O. Box 550, Farmington Hills, MI 48332
Phone: +1.855.851.2974 | Fax: +1.855.851.2971 | Email: NCCCcare@imglobal.com

americorpsnccc.imglobal.com

