
AmeriCorps

Health Care: BCS Option II

PLAN

INFORMATION SUMMARY



Underwritten by BCS Insurance Company,
Chicago, Illinois



Administered by Strategic Resource Company

AmeriCorps Health Care: BCS Option II

Underwritten by BCS Insurance Company, Chicago, Illinois

This plan is provided under a group insurance policy issued by BCS Insurance 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 elective termination of pregnancy are limited to \$500. 5) Benefits for eligible expenses incurred due to a motor vehicle accident are limited to \$10,000. 6) Benefits for eligible expenses incurred due to sports-related accidents (interscholastic, intercollegiate, club or professional) are limited to \$5,000. 7) Benefits for eligible expenses for emergency professional ambulance services to the nearest hospital are limited to \$250. 8) Benefits for eligible expenses incurred for specified therapies, including acupuncture and physiotherapy and chiropractic services, are limited to \$10,000 (inpatient) and \$1,000 (outpatient), and if immediately following a covered hospital confinement or surgery. 9) 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) for care or treatment which is not medically necessary, including preventative medicines, routine physical examinations, 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 BCS Option II; 3) for professional services rendered by an immediate family member or someone who lives with you; 4) due to any injury occurring while performing duties under the AmeriCorps program if you are or could be covered under Workers' Compensation or any similar program; 5) 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; 6) resulting from your use of alcohol or intoxicants, or any other drugs, unless as prescribed by a doctor; 7) resulting from self-inflicted injury, suicide, or any attempt at such; 8) resulting from war, declared or undeclared; service in the Armed Forces of any country; riot; civil commotion, or acts of terrorism; 9) 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); 10) for treatment of teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, TMJ, dysfunction or skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. This exclusion does not apply to the repair of sound natural teeth which will be limited to \$250 per tooth per injury; 11) for eye examinations, glasses or contact lenses, or hearing aids; 12) for treatment of congenital anomalies and conditions arising from them; 13) for cosmetic surgery except breast reconstruction due to a mastectomy, or when necessary as the result of an injury that necessitated treatment within 24 hours of the accident; 14) for treatment of deviated nasal septum, including submucous resection and/or surgical correction; 15) in connection with an organ transplant; and 16) used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered usual & customary.

With respect to the Accidental Death Benefit under the policy for the BCS 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 BCS 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.

COBRA

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 COBRA Election Form to the person's last known home address.