AmeriCorps USA Health Insurance Frequently Asked Questions

How do I enroll in the insurance plan?

You are automatically enrolled as of your first day of your term of service. Other than your initial enrollment paperwork, including the health insurance verification form, there are no additional health insurance enrollment requirements. Your insurance begins the first day of your term of service and continues until 12:00 MIDNIGHT of the day you end your term of service.

Who is covered?

This insurance policy covers only full-time AmeriCorps*USA members (not VISTA - they have a separate insurance plan and company), and does not cover any spouse or dependents they may have.

Can I waive coverage?

It is a requirement of the insurance company that we enroll all of our members; however, in some circumstances, coverage can be waived. For example, if you are receiving SSI benefits and they provide health insurance, having this other policy can jeopardize those benefits. In this situation, we would waive coverage under the AmeriCorps insurance.

If I have other insurance, does it become secondary? And what does secondary coverage mean?

If you have other insurance prior to enrolling in AmeriCorps and continue that coverage, that will be your primary insurance. This means that you would bill your other insurance company FIRST. Your AmeriCorps insurance becomes your secondary insurance. Whatever the first insurance company did not cover of your medical claim, you can submit to the AmeriCorps insurance and providing that your deductible has been satisfied, they would pay 80% of reasonable and customary charges.

What is the percentage of co-pay?

This policy is not a co-pay plan. There is a $75 deductible and then the insurance company will pay 80% for the first $1,000.00 of reasonable and customary charges per condition. The member pays 20% (so in effect, that would be your co-pay).

Is there a deductible for both medical and pharmaceutical?

No, there is just one deductible ($75) including both medical and prescription coverage. You are responsible for the first $75 in medical claims. After the deductible is satisfied, the insurance company pays 80% of reasonable and customary covered services per injury or illness. The deductible is a one time deductible for the policy year, which runs September 1- August 31.

Can you explain the deductibles and partial payments?

Your deductible is $75 (for your term of service) so you must pay the first $75 in medical claims. When the insurance company gets a bill, they will look to see if you have submitted a prior claim and if not, they will subtract $75 from the bill as your responsibility. They then pay 80% of reasonable and customary charges per condition. For example, for your first claim, you would have to pay $75 and 20% of the balance. The next bill that comes in, the insurance company pays 80% and you pay 20%, etc.

Do I mail my deductible to someone?

No, the insurance company, when processing your first claim, will see that you haven't paid the deductible and subtract $75 from the amount of the claim they are processing. They will send the portion they are paying to the doctors' office, or to you if you have already paid the doctor. The doctor would then bill you for the remaining balance.

Is there any way to waive the $75.00 deductible?

No.

How does the prescription drug benefit work?

Prescription drugs are covered at an 80% reimbursement rate of reasonable and customary charges. Once the $75 deductible has been satisfied, your prescriptions will be reimbursed at 80% of the cost. As prescriptions are reimbursed, you don't receive a prescription card and may go the pharmacy of your choice. You do not have to show your medical card. Once you have paid for your prescription, you may fax your pharmacy prescription receipt (not just the cashier receipt), to the insurance company or Washington Service Corps insurance manager for reimbursement. Be sure that your name, social security number, policy number and your home address are shown on the fax.

How do I know what doctor to see?

The AmeriCorps insurance is not a "Preferred Provider" policy; therefore, you may go to the doctor of your choice. You do not need to see a doctor off of a list provided by the insurance company.

What type of doctors does the plan cover?

The policy covers licensed practitioners for medical services in the treatment of an illness or injury, preventive care, etc. but does not cover vision or dental services.

What should a member do at the beginning of their term when they don't have an insurance card and need to seek medical attention or have prescriptions filled?

Members needing to seek medical treatment prior to receiving their insurance cards should contact the Washington Service Corps Insurance program manager, Terri Jack at (360) 438-4012 or toll-free at 1-888-713-6080. Many times the Service Corps can expedite enrollment of a member and obtain the member ID number for the member to use at the doctor's office. Because the insurance covers prescriptions on a reimbursement method, the member would not need to have their insurance card in order to purchase prescriptions. The member can then fax the prescription receipt to Terri Jack and she will ask the insurance company to expedite the reimbursement process.

Are pre-existing conditions covered?

If you did not have similar insurance at least 60 days prior to enrolling in the AmeriCorps insurance, there is a 90-day wait period before your pre-existing condition would be covered. If you had similar insurance for at least three consecutive months prior to enrolling, there would be no wait period on the pre-existing condition and services would be covered from your first day of enrollment.

What is a pre-existing condition?

A pre-existing condition is a sickness or injury for which advice was given, or for which a physician recommended or provided treatment within the three (3) months prior to the covered person's effective date of coverage under this policy.

I know that some medications are covered for medical conditions that are not (i.e. the insurance will pay for the medications but not the doctor appointments). Can you elaborate on that a bit or give a list of examples?

Normally, if the medical services are not a covered service, any prescriptions resulting from that service would not be covered either. The only example that the insurance company could conceive would result in this scenario is if a member received the "Morning After" pill. Contraceptives are covered by the policy, but the medical appointment would be considered an elective consultation and therefore; would not be covered.

What exactly is the mental health coverage?

Mental health coverage covers both in-patient and out-patient services and are paid at the 80% rate of reasonable and customary charges, just as any other medical services. However, there is a $5,000 limit on this type of coverage during any consecutive 24-month period. (This would apply for second year members). The $5,000 would be for combined in-patient and out-patient treatment, rather than $5,000 for in-patient and $5,000 for out-patient.

Is chiropractic care covered?

Chiropractic care is covered, if it is in the treatment of an illness or injury at the 80% of reasonable and customary charges. The chiropractor must be a licensed provider. If you are going as a preventive measure, it is not subject to the deductible and the insurance company will pay up to $150 for preventive care. That is $150 total for preventive care, not per visit.

Are we covered to visit naturopathic doctors and chiropractors? Does massage therapy fit under the physical therapy component?

Naturopathic and chiropractic doctors ARE covered, as long as they are licensed practitioners. And massage therapy is covered as part of a physical therapy session, provided it is in the treatment of an injury. The massage therapist again, would have to be a licensed practitioner. If you are just having a massage because it feels good, that is not covered.

Are there any options for vision / dental insurance?

No.

Does the insurance pay for preventive care (yearly physicals)?

Yes, the insurance pays up to $150 for preventive care. Yearly physicals are considered preventive care and are not subject to the deductible.

How do I bill the insurance company?

In most cases, the doctor's office will bill the insurance for you. If you have paid the doctor's office, or have a prescription you need to be reimbursed for, you can submit your claim by faxing it to the Washington Service Corps Insurance Manager.

How long does it take to be reimbursed once you have submitted bills?

The length of time can vary, depending on whether or not the insurance company needs additional information. The standard claims processing time is 15 to 30 days.

Does the insurance cover lab fees?

Yes, medically necessary services.

Does it cover emergency as well as regular dental?

No, the insurance policy does not cover any dental work unless it is an injury to a sound natural tooth.

Will my insurance cover athletic injuries?

If the injury is related to interscholastic, intercollegiate, professional sport, contest or competition the services will not be payable.

Can I go to a specialist or must I get a referral from a general practitioner?

Yes, you may go to any licensed physicians practicing under the scope of their license.