Good Morning,

Welcome back as we begin the 2019-20 school year. This is just a brief update on the voluntary student accident insurance that is offered through Conroe ISD. The insurance company has requested that the insurance brochures be made available at each front office and that the information and how to purchase be digital and made available on each campus' webpage. The brochures should be delivered to each campus this week and will be addressed to the "Principal." Please remember that this is a voluntary accidental policy only. It will not cover illness and coverage will be only for those who purchase the policy. The policy has a few options so the parent/guardian may choose which is best for their own situation.

The following are a few instructions for each campus:

1. Do not accept money for payment of the policy. This should be mailed directly to the company by the parent/guardian. There is also an online payment option for enrollment.
2. There will be claim forms in each box of brochures that you receive. Please put those in a safe place.
3. The Principal may choose to be responsible for completing the claim forms or may appoint someone to be in charge of this (usually the campus Nurse or an Assistant Principal).
4. When completing a claim, the school designee (Principal or Nurse) must complete the top half of the form, then sign and date it the actual date that the form is completed. Please do not allow the parent/guardian to complete the top half of the form--the insurance company will send it back.
5. Make a copy of the form once the top half is complete and the school official has signed it. Place it with the student's medical record. Once a claim form has been completed, please do not complete a second form for the same injury; as the insurance company will reject the claim. You may give the parent a copy of the completed original form in case the original gets lost.
6. The parent/guardian will need to complete the bottom half of the claim form. The form must be complete in its entirety before mailed to the insurance company! Anything left blank will result in the claim form being returned and processing will be delayed until entire the form is correctly complete. It is best to write "none" and not "n/a."
7. The original completed form should be mailed (by the parent/guardian) directly to the insurance company and the address is on the form. Therefore, please advise the parent/guardian to make several copies of the entirely completed form. They may give those copies to all medical providers that provide services for the injury. (i.e. Surgeon, physical therapy, anesthesia etc).
8. The parent/guardian must send all claims, correspondence, and paperwork directly to the insurance company. Please do not accept any bills or paperwork as CISD is not the insurer.
9. The claim form must be filed within 90 days of the injury (stated on the claim form). If a parent requests a claim form after that time has expired, go ahead and complete the form but please point out to the parent that time has expired. The insurance company will let the parent know if coverage is accepted or denied.
10. To determine if a student has purchased the policy you may contact me or the Lead Athletic Trainer for your high school feeder zone. The list is at the end of this email.
11. Instructions are also on the back/second page of the claim form.

I am attaching an informational handout that may be used online that contains the links to the brochures and information to purchase online. I am also attaching copies of the brochures and claim forms in English and Spanish.

Caney Creek High School - Chad Miller, LAT, ATC 936-709-2217 cfmiller@conroeisd.net
Conroe High School - Robert Phillips, LAT, ATC 936-709-5829 rphillips@conroeisd.net
Grand Oaks High School - Todd Matz, LAT, ATC 281-939—0063 tmatz@conroeisd.net
Oak Ridge High School - Rebecca Mathews, LAT 832-592-5438 rmathews@conroeisd.net
The Woodlands College Park High School - Jason McDonald, LAT 936-709-3044 jmcdonald@conroeisd.net
The Woodlands High School - Charlotte LaVerne, LAT, ATC 936-709-1068 claverne@conroeisd.net

I hope everyone has a great school year, and if you have any questions, please do not hesitate to call or email me.

Sincerely,

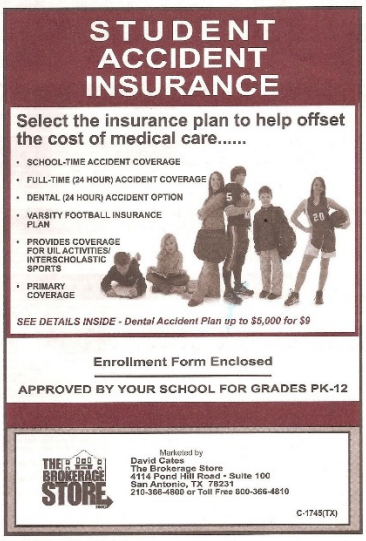
Charlotte LaVerne, Med, LAT, ATC

Voluntary Student/Athletic Insurance

Under State Law, school districts in Texas are not liable for accidents which occur in schools. It is important to understand the school/district IS NOT responsible for medical payments or bills for your child. If your child is injured during **ANY SCHOOL, ATHLETIC OR UIL SPONSORED ACTIVITY**, all medical charges are your responsibility.

Conroe ISD has purchased a **SUPPLEMENTAL** accident policy which covers students (grades 7-12) for UIL activities. This is a **limited benefit policy** and any charges not covered by this policy are your responsibility.

For the benefit of parents and as a service to the community, Conroe ISD has contracted with The Brokerage Store and Student Assurance Services to provide **optional** student accident insurance for your child. This is a valuable option to parents/guardians who, because of various reasons, do not have health insurance. It is also an excellent way to supplement your health insurance if you have a large deductible or co-insurance, including HSA Plans.



Plans include:

1. School time only which covers accidents during school time only
2. 24-hour coverage which covers 24 hours a day, 365 days a year, any place and any time
3. Football coverage for Varsity players grades 10-12
4. Dental coverage

IF PURCHASED, THIS INSURANCE IS PRIMARY INSURANCE TO ALL OTHER EXISTING POLICIES.

In order to enroll your child in the **VOLUNTARY STUDENT/ATHLETIC ACCIDENT INSURANCE** plan, please remember to:

1. Contact your child's school office for a brochure: OR
2. Go online to Student Assurance Services, then follow the prompts:
    1. Choose "**Find My School**"
    2. Choose "**State**" (Texas)
    3. Choose "**School District**" (Conroe ISD)
    4. Choose "**Purchase Online**" **OR** download the brochure for the current school year.

For questions please see Frequently Answered Questions.

***The above is just a brief description of the benefits available. This is not a contract, policy, or outline of coverage. All benefits are subject to maximum amounts, limits, exclusions and other policy provisions.

Envíe el formulario completo por correo a:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196 , STILLWATER, MINNESOTA 55082
Phone: (800) 328-2739; Fax (651) 439-0200
Email for Claims: claims@sas-mn.com

USA H&W Network
Provider Selection
800-USA-3860

Asegúrese de utilizar los servicios de un proveedor de la MCO de los EE. UU. para recibir descuentos por los servicios prestados por los médicos y centros participantes de la Red de MCO de los EE. UU.

Este plan complementa toda otra cobertura de seguro. Primero debe presentar una reclamación con su otro seguro.

COMPROBANTE DE RECLAMACIÓN: *cuando la lesión derive en un tratamiento realizado por parte de un Médico, complete este formulario y envíelo a Student Assurance Services, Inc. en un plazo de 90 días a partir de la fecha de la lesión.*

A COMPLETAR POR PARTE DE UN FUNCIONARIO DE LA ESCUELA

PARTE A: AVISO DE LESIÓN

1. Nombre de la escuela _____ Nombre del distrito escolar _____

   Dirección de la escuela _____
   (Ciudad) (Estado) (Código postal)

2. Nombre del Asegurado _____ Grado _____

3. Fecha de la lesión _____ ☐ a.m. ☐ p.m.

4. ¿Bajo la supervisión de quién? _____ ¿Se produjo la lesión en presencia de él/ella? _____

5. El accidente se produjo mientras el Asegurado participaba en:

UNA ACTIVIDAD INTERESCOLAR DE LA UIL		UNA ACTIVIDAD NO INTERESCOLAR DE LA UIL	
( ) Práctica	¿Qué deporte/actividad?	( ) Viaje hacia/desde la escuela	( ) Actividad no escolar
( ) Juego/Evento		( ) En el salón de clases	( ) Otro – ¿Actividad?
( ) Viaje	_____	( ) Educación física	_____
		( ) En el recinto escolar	

6. Parte del cuerpo lesionada _____ ☐ Lado derecho ☐ Lado izquierdo

7. Describa en detalle cómo y cuándo se produjo la lesión _____

_____

_____

_____

Informado por _____
(Firma del funcionario de la escuela) (Cargo) (Fecha)

(*Uno de los padres puede completar la Parte A si se adquirió Cobertura de Tiempo Completo).

CONSULTE LA INFORMACIÓN IMPORTANTE AL DORSO

A COMPLETAR POR PARTE DEL PADRE, MADRE O TUTOR

PARTE B: DECLARACIÓN DE LOS PADRES

1. Nombre del estudiante _____ Fecha de nacimiento _____

   N.º de Seguro Social del estudiante ☐☐☐-☐☐-☐☐☐☐

   Nombre del padre _____ Relación con el asegurado _____

   Dirección de envio _____
   (La calle, la Ruta o Caja) (Ciudad) (Estado) (Código postal)

2. Número de teléfono particular _____

3. Ocupación del padre _____ Empresa _____

   Ocupación de la madre _____ Empresa _____

4. Indique su cobertura familiar o grupal, por favor.

   Nombre de la compañía de seguro _____ ☐ Grupal ☐ Individual ☐ N.º de póliza _____

   Dirección _____
   (Calle) (Ciudad) (Estado) (Código postal)

Por este medio autorizo a los médicos, facultativos médicos, hospitales, clínicas u otros centros médicos o centros de salud relacionados, compañías de seguro, u otras organizaciones, instituciones, o personas que posean cualquier registro o conocimiento de la salud física o mental del reclamante, a proporcionar la información a STUDENT ASSURANCE SERVICES, INC. A los efectos de facilitar la rápida presentación de tal información, autorizo a todas las fuentes mencionadas a proporcionar los referidos registros o conocimiento a cualquier agencia que la compañía de seguro haya contratado para reunir y transmitir tal información. Una fotocopia de esta autorización tendrá la misma validez que el original. Esta autorización vence un año después de la fecha de la firma.

_____ _____ _____
(Fecha) (Nombre del estudiante/paciente en letra de imprenta) (Firma del padre, madre o tutor)

NOTIFICACIÓN: *toda persona que, a sabiendas, tergiverse o falsifique la información esencial que se solicita en este formulario puede estar sujeta, una vez condenada, a penas de multa o prisión.*

ATTENTION PARENTS

*******PARENTS "YOU'RE RESPONSIBLE"*******

Dear Parents,

Below are steps for completing the Claim Form. Should you have any questions, contact the School Trainer/Adminstrator or call the number listed on the claim form. The school "**IS NOT"** responsible for your medical payment or bills for your child. All medical charges are **"YOUR RESPONSIBILITY"** if your child is injured during **ANY** Athletic (or UIL Activity in Texas) or during any school sponsored and supervised activity.

HOWEVER, the school may have purchased a supplemental policy to cover any charges in excess of your own insurance policy. If you have **NO OTHER INSURANCE** for your child, this policy will then pay first or primary. This policy has dollar maximums and benefit limitations. Any charges above the policy benefit limits are **YOUR RESPONSIBILITY.** This policy was purchased by the district based on funds available. Please be aware that this policy by **NO MEANS** was it intended to cover all medical bills for your child. **Your child's treatments and medical charges are your responsibility.**

Please contact the school trainer or administrator before seeking medical treatment or services.

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. Only one claim form for each accident needs to be submitted.
2. The claim form and benefit summary are available at our website: **www.sas-mn.com**. However, this is not a guarantee of benefits but only an explanation that is subject to all applicable terms, conditions, limitations and exclusions of the plan.
3. A school official **must** complete Part A for all school related accidents. The parent or guardian must complete **all** questions in Part B – Parent Statement. If the accident is not school related, the parent or guardian **may** complete both Part A and Part B of the claim form.
   NOTE: This claim form or a copy of the claim form must be presented to the physician or facility in order to obtain the Lonestar Provider Discount.
4. Send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **These itemized bills often called UB-04 or CMS-1500 must contain the provider address, date of service, procedure code, diagnosis code, and the provider's federal tax ID number and NPI number. Providers may submit itemized bills directly to the claim administrator at the address below.**
5. Submit copies of all bills to your primary family and/or group insurance first, even if you have a large deductible or copay. This plan is supplemental to all other insurance coverage (Blue Cross, Group Health, Prudential Insurance, etc.). This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage.
6. After you have received payment or copies of "Explanation of Benefits" (EOBs) from your primary insurance plan, fax, email or **mail the completed claim form, copies of student's itemized bills and other insurance EOBs to:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
FAX: (651) 439-0200
EMAIL: CLAIMS@SAS-MN.COM

Please keep a copy of the claim form for your records

NO CLAIM CAN BE PROCESSED UNTIL ALL THE ABOVE DOCUMENTS ARE PROVIDED
IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO SUBMIT THE CLAIM FORM AND ITEMIZED BILLS

PREFERRED PROVIDER DISCOUNT PROGRAM

Student Assurance Services, Inc. has contracted for fee discounts for services received from physicians and facilities participating in the LONESTAR network which is part of the USA Managed Care Organization Network (USAMCO). Please note that benefits are payable as described whether you use a LONESTAR preferred provider or not. However, it is to your advantage to use a LONESTAR preferred provider since your costs may be reduced. A directory of LONESTAR preferred physicians and facilities is available at the USAMCO Network website **www.usamco.com/lonestar**.

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.

Email, Fax or Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196, STILLWATER, MINNESOTA 55082
Phone: (800) 328-2739; Fax (651) 439-0200
Email for Claims: claims@sas-mn.com

USA H&W Network
Provider Selection
800-USA-3860

To receive fee discounts, use the services of a LONESTAR preferred physician or facility. The LONESTAR Network is part of the USAMCO provider network.

This plan is supplemental to all other insurance coverage. You must file a claim with your other insurance first.

PROOF OF CLAIM: *When Injury results in treatment by a Physician, complete this form and submit to Student Assurance Services, Inc. within 90 days from date of injury, not to exceed one year.*

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____

   School Address _____
   (City) (State) (Zip)

2. Name of Student _____ Grade _____

3. Date of Injury _____ ☐ AM ☐ PM

4. Under whose supervision? _____ Was he/she a witness? _____

5. The accident was incurred while the Insured was participating in:

1. INTERSCHOLASTIC or (UIL Activity in Texas)

☐ Practice ☐ Travel to/from Sport/Activity
☐ Game/Event
What Sport/Activity? _____

2. NON-INTERSCHOLASTIC or (UIL Activity in Texas)

☐ Travel to/from school ☐ Non-school activity
☐ In classroom ☐ Physical Education
☐ Other - Activity? _____
☐ On school grounds

6. Part of the body injured _____ ☐ Left side ☐ Right side

7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____
(Signature of School Official) (Title) Date (mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
See Attached Claims Filing Information

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Date of Birth _____
   Date (mm/dd/yyyy)

Students Social Security # _____

Parents Name _____ Relationship to Insured _____

Mailing Address _____
(Street, Route, or Box) (City) (State) (Zip)

2. Home phone number _____

3. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____

4. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No

   Name of Insurance Company _____

   ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ None

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed. By entering my name below, I warrant that all of the information provided is true, complete, and accurate.

_____ _____ _____
Date (mm/dd/yyyy) (Print Name of Student/Patient) (Signature of Parent or Guardian)

ATENCIÓN PADRES

*******PADRES: "USTEDES SON RESPONSABLES"*******

Estimados padres:

A continuación se indican los pasos para completar el formulario de reclamación. Si tienen alguna pregunta, comuníquense con el entrenador de la escuela o llamen al número indicado en el formulario de reclamación. La escuela "**NO ES"** responsable por el pago de servicios o facturas médicas de su hijo. Si su hijo resulta lesionado durante **CUALQUIER** evento atlético o evento patrocinado de la Liga Interescolar Universitaria (University Interscholastic League, UIL), todos los cargos médicos son **"SU RESPONSABILIDAD".**

SIN EMBARGO, la escuela ha adquirido una póliza complementaria para cubrir cargos que excedan la propia cobertura de seguro de ustedes. Si **NO TIENEN NINGÚN OTRO SEGURO** para su hijo, entonces esta póliza pagará en primer lugar. Ésta es una póliza de beneficios limitados y todo cargo que exceda los límites de beneficios de la póliza será **SU RESPONSABILIDAD.** El distrito adquirió esta póliza sobre la base de los fondos disponibles. Por favor, tengan en cuenta que ésta es una póliza de beneficios limitados y **DE NINGUNA FORMA** tiene la finalidad de cubrir todas las facturas médicas de su hijo. **Los tratamientos y cargos médicos de su hijo son su responsabilidad.**

Por favor, pónganse en contacto con el entrenador o administrador escolar antes de obtener tratamiento o servicios médicos.

PASOS A SEGUIR AL PRESENTAR UNA RECLAMACIÓN:

1. Un funcionario de la escuela **debe** completar la Parte A para todos los accidentes relacionados con la escuela. El padre, la madre o el tutor debe completar **todas** las preguntas de la Parte B: Declaración de los padres. Si el accidente no se relaciona con la escuela, el padre, la madre o el tutor **puede** completar la Parte A. **Este formulario de reclamación debe presentarse al médico o al centro a fin de obtener el Descuento para Proveedores de Organizaciones de Atención Administrada (Managed Care Organization, MCO) de los EE. UU. No entregue el formulario de reclamación al proveedor ni al centro. Complételo y envíelo directamente a la Oficina de Reclamaciones en la dirección indicada a continuación.**

2. Envíe copias de las **facturas detalladas.** Éstas son las facturas originales que usted recibe, no los estados de cuenta mensuales. **Estas facturas detalladas, a menudo denominadas UB04 o CMS 1500, indican la dirección, el código de procedimiento, el código de diagnóstico y el número de identificación fiscal del proveedor.**

3 Presente copias de todas las facturas a su seguro familiar y/o grupal, aun si tiene un deducible grande. Este plan complementa toda otra cobertura válida. Primero debe presentar una reclamación con su otro seguro. Este plan no cubre sanciones impuestas por no utilizar los proveedores preferidos o designados por su cobertura principal. Después de que haya recibido el pago o las copias de la "Explicación de Beneficios" (EOB) de su compañía de seguro o su administrador de seguro familiar (Blue Cross, Group Health, Prudential Insurance, etc.), **envíe nuestro formulario de reclamación, copias de las facturas detalladas y todas las Explicaciones de Beneficios de su otro seguro a:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
1-800-328-2739

NO PUEDE TRAMITARSE RECLAMACIÓN ALGUNA SI NO SE HAN PROPORCIONADO TODOS LOS DOCUMENTOS MENCIONADOS CON ANTERIORIDAD.

PROGRAMA DE DESCUENTOS PARA PROVEEDORES PREFERIDOS

Student Assurance Services, Inc. ha contratado los descuentos por servicios recibidos de médicos y centros participantes en la Red de Organizaciones de Atención Administrada de los EE. UU. Tenga en cuenta que los beneficios son pagaderos de la forma descrita, ya sea que utilice un proveedor participante o no. Sin embargo, para usted es más ventajoso utilizar un proveedor participante dado que tendrá costos más bajos. En el sitio web de la Red de MCO de los EE. UU. hay una lista de los médicos y centros participantes a su disposición: **www.usamco.com**.

CONSULTE LA PÓLIZA BASE EMITIDA A LA ESCUELA/DISTRITO ESCOLAR PARA OBTENER DETALLES ESPECÍFICOS.