san josé·evergreen
COMMUNITY COLLEGE DISTRICT

NOTICE TO STUDENTS
HOW TO FILE A CLAIM WITH STUDENT INSURANCE
Claim & HIPAA Forms Attached

If you are a student enrolled and registered at either San Jose City College or Evergreen Valley College, and are injured on campus or while participating on a college athletic team, you may be eligible to file for accidental insurance benefits under the Student Insurance policy provided to you by the San Jose Evergreen Community College District.

What is Student Insurance?

Student Accident Insurance is not "health insurance", but instead is "accident insurance" and will not cover illnesses unrelated to an accident.

What are the forms attached to this Notice?

You should find a Claim form, a HIPAA form, and a brochure known as the Anthem Information Bulletin attached to this Notice. In order to file a claim with Student Insurance, you will need to fill out the Claim and HIPAA forms as explained below. The Anthem Information Bulletin explains the Student Insurance program including who is eligible for benefits under the policy, deductibles, maximum benefits, and common exclusions from coverage.

Should you file a claim if you already have personal health insurance coverage?

If you do not have health insurance, the Student Insurance policy will provide primary coverage for eligible claims. If you have a personal health insurance policy, the Student Accident Insurance policy is secondary to any benefits you are eligible to receive under your personal policy. If you are enrolled in Medicare, Medicaid, or a military benefits program, Student Insurance will inform you of how eligible benefits will be processed under Student Insurance. While Student Insurance is a secondary policy, it may cover out-of-pocket expenses not otherwise covered under your personal health insurance policy or governmental benefits.

How do you file a claim with Student Insurance?

1. Fill out and sign the HIPAA Form legibly (if you are under 18 your parent/guardian will need to sign)
2. Fill out the top section of the Accident Claim Form legibly (Items 1-5) and sign it twice—at the bottom of the first section and at the bottom of the Claim Form
   NOTE: You must provide all your primary insurance information in Section 4 in order for the Student Insurance carrier to consider any eligible claim! No information = delays in processing
3. Turn in both the Claim and HIPAA Forms to Health Services, or if not open, to Campus Police. If you are an athlete and were injured during practice or in competition, please turn in your claim form to your coach or other designated school official in Athletics.
4. Your claim form is not complete until a college official fills out the remaining sections of the Claim Form and sends both the Claim and HIPAA form to Student Insurance. Do not try to file the claim yourself. Once your claim is filed, Student Insurance will contact you directly.

5. The deadline to file a Claim and HIPAA Form is 90 days from the date of the accident or injury. However, the Claim and HIPAA Form should be filed as soon as possible so that there is no delay in your receipt of benefits.

Student Accident Insurance is an Anthem Blue Cross PPO. The Student Insurance policy does not restrict you from seeing any health professional you wish to see. However, in order to receive full benefits under the policy you must receive treatment from an Anthem network provider. Please contact Anthem directly at (310)826-5688 for assistance locating an Anthem network provider or if you have any questions about your Student Insurance claim.

S.A.I.N.
Student & Athlete Insurance Network

HIPAA Individual Authorization

Anthem

Instructions: Please complete the form in its entirety and include as much information as possible.

Individual last name	First name		M.I.	Group ID no.
College name	Social Security no. (optional)	Date of birth (MMDDYY)	Daytime phone no. (with area code)	
Individual street address	City		State	ZIP code

Part A: I authorize the following person or types of people to disclose my information:

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates and agents.

Part B: I authorize the following person or types of people to receive my information (the person receiving the information must be 18 years of age or older):

S.A.I.N. Health Group plan representatives

Athletic Personnel and/or Director of Nursing – Name: _____

Chief Business Official and/or Administrator – Name: _____

Name and relationship to the individual: _____

Part C: I authorize the following information to be used or disclosed on my behalf:

Only limited information may be disclosed (check all applicable blocks below):

Limited Information:
- ☑ Benefits & coverage
- ☑ Billing
- ☑ Claims & payment
- ☑ Diagnosis & procedure
- ☑ Eligibility & enrollment
- ☑ Medical records (excludes psychotherapy notes[1])
- ☑ Physician & hospital
- ☑ Treatment
- ☑ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all blocks that apply to you):

☐ All sensitive information **OR** Just information about topics checked below:

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse[2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

Part D: The purpose of my authorization is (check one block):

☐ To disclose the information at my request

☐ For the following purposes: **Auditing, enrollment, billing, financial analysis, stop-loss/reinsurance, and benefit analysis.**

Part E: Expiration date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- The date my coverage ends (only if disclosure requested by insurance company)
- One year from the signature date below
- Upon the following date, event or condition (within the one year time frame): _____ (MMDDYY)
- Accident date: _____ (MMDDYY)

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, enrollment or eligibility for benefits on signing this authorization. I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Individual signature	Date (MMDDYY)
X	

Designated legal representative/guardian

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name)	Legal relationship to individual

Individual signature	Date (MMDDYY)
X	

1 **Note:** This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.

2 I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Reset Form | Save and Print

Please keep a copy of this form for your records and return the completed form to:

Student Insurance
P.O. Box 4998
West Hills, CA 91308

Email to: claims@studentinsuranceusa.com
Phone: 310-826-5688
Fax to: 310-826-1601

Corporate Privacy has approved this form and it is an accepted HIPAA Authorization for the S.A.I.N. (Student Athlete Insurance Network) Group. 1/2017

Student & Athlete Insurance Network Accident Claim Verification Form

Claim control no. for Anthem Blue Cross use only

Providers mail with bills to:
Student Health Claims Dept.
Attn: Claims Manager
21215 Burbank Blvd.
Woodland Hills, CA 91367
Reference S.A.I.N. Program when calling toll free: 866-811-7946
For priority issues please fax to: 855-396-8418

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This policy is secondary coverage to all other policies, except as required by state or federal law.

To be completed by student or athlete

Student last name	First name	M.I.	Birthdate (MMDDYY)

Street address	City	State	ZIP code

Phone no.	Email address

1. Give full description of injury from which you are now suffering. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred.
Date: ____ (MMDDYY) Time: _____ ☐ a.m. ☐ p.m.

3. When did you first consult a physician for this condition?
Date: ____ (MMDDYY)

4. Do you have other insurance? ☐ Yes ☐ No If yes, complete the following.
Other insurance coverage is through: ☐ Parent ☐ Self ☐ Spouse
Type of coverage: ☐ Individual ☐ Through employer
Type of plan: ☐ HMO ☐ Other: _____
Group/policy no.: _____
Policyholder name: _____
Employer name (if applicable): _____
Insurance company name: _____
Insurance company address: _____

5. Are you an international student?
☐ Yes ☐ No

Sign your full name X	Date (MMDDYY)

On-Campus accidents — To be completed by college official

College name	Group/policy no.	Time classes/activity began on date of injury: Time: _____ ☐ a.m. ☐ p.m.

Did accident occur (check yes or no)	Yes	No		Yes	No
a. While claimant was supervised?	☐	☐	e. During intercollegiate practice?	☐	☐
b. During sponsored activity?	☐	☐	f. During intercollegiate competition?	☐	☐
c. During programmed hours?	☐	☐	g. While traveling to or from a regularly scheduled activity in a supervised group?	☐	☐
d. On school premises?	☐	☐			

I hereby certify that the statements made above are correct to the best of my knowledge and belief and that the above named claimant was insured hereunder at the time of the accident;

College official signature X	Printed name	Title	Date (MMDDYY)

Intercollegiate athletic accidents — To be completed by athletic official

Intercollegiate sport name	Position played	Did injury occur during non-traditional sports session? ☐ Yes ☐ No	☐ Practice ☐ Competition

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision on: → Date (MMDDYY)

Athletic official signature X	Printed name	Title	Date (MMDDYY)

Athletic and on campus accidents – To be completed by college official

Name of class or P.E.: _____

Authorization to pay benefits to provider

I authorize payment of medical payments to physician or supplier for services described for the attached statements:

Student/athlete signature X	Date (MMDDYY)

Reset Form Save and Print

To the student

- Use this form each time you visit a physician or hospital as a result of an accidental injury incurred while attending regularly scheduled classes or while participating/attending a college-sponsored event or competition.
- **ONLY** use this form after the college has properly authorized and completed their portion.
- Give this form to the physician or hospital so they may properly submit the claim to Anthem Blue Cross.
- Copay Reimbursement – may be considered **only if** (1) a HCFA 1500 billing or UB-04 billing is submitted with a copy of the primary insurance Explanation of Benefits (EOB), and (2) a receipt indicating the amount of the copay. Balance due bills or statements are not acceptable documents for processing of payments.

To the provider

- This plan covers the student for accidental injury while attending regularly scheduled classes or while participating/attending a college-sponsored event or competition.
- **Please check to see that the appropriate college representatives have completed their portion before submitting the claim.**
- To insure prompt payment, please attach all (UB-04 and/or HCFA 1500) billings to this form and submit to:

  Student Health Claims Dept.
  Attn: Claims Manager
  21215 Burbank Blvd.
  Woodland Hills, CA 91367

  Reference S.A.I.N. Program when calling toll free: 866-811-7946
  For priority issues please fax to: 855-396-8418

Balance due bills or statements are not acceptable documents for processing of payments.

- Electronic Billing is not an option with this program. This program does not accept 'Electronic Billing.' All bills must be submitted via USPS with a copy of the Claim Form attached.
- **Colleges send HIPAA and Claim Forms to:**
  Student Insurance
  P.O. Box 4998
  West Hills, CA 91308
  Email to: claims@studentinsuranceusa.com
  Fax: 310-826-1601
- For additional information, please contact Student Insurance Information at 310-826-5688 or Anthem Blue Cross at 866-811-7946.

EXCESS COVERAGE:

We will reduce the amount payable under this plan to the extent expenses are covered under any other plan. We will determine the amount of benefits provided by other plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from other plans includes any amount to which the insured person is entitled, whether or not a claim is made for the benefits. This policy is secondary coverage to all other policies, except as required by state or federal law.

ACCIDENTAL DEATH AND DISMEMBERMENT:

Loss of Life	$10,000
Single Dismemberment	$1,000
Double Dismemberment	$5,000

The exclusions that apply to this benefit are in the Common Exclusions section.

WHERE & HOW TO REPORT AN ACCIDENT:

Immediately report all accidents to the instructor, coach, athletic trainer, or the college health center if one is available. All accidents must be reported to **COLLEGE AUTHORITY** and Health Center as soon as possible. An accident report is required to substantiate an insurance claim. Contact the health office or athletic trainer for insurance reporting forms and information. Time is of the essence!

DO NOT DELAY REPORTING: Written notice of claim must be submitted within **120 days** after the date of the accidental injury. Proof of loss (itemized bills) must be submitted within 120 days after services and supplies are received. Any bills submitted more than 12 months after the date of the service will be denied per the policy terms.

PROVIDERS: any bills, explanations of benefits, etc., should be mailed directly to:
Student Health Claims Dept.
Attn: Claims Manager
21215 Burbank Blvd.
Woodland Hills, California 91367.

Anthem Blue Cross Life and Health Insurance Company may be contacted at **(866) 811-7946**.

The Plan is administered by Student Insurance, 6320 Canoga Avenue, 12th Floor, Woodland Hills, CA 91367. For more information after a claim is filed, College and/or Students may contact Student Insurance at **(310) 826-5688**.

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PLEASE NOTE: This is a brief outline of the current student accident insurance program. It is presented in general terms and does not include all the exact provisions and conditions of the policies involved. The master policies are on file at each college and the district office once approved by the California Department of Insurance. No individual certificates will be issued. If any statements in this Information Bulletin and any policy differ, the policy will govern.

Anthem

SAN JOSE-EVERGREEN CCD

2022-2023

Student Athlete Insurance Network

Information Bulletin Plan E

No Deductible Policy

Group ID Number: Evergreen Valley 1157RS
San Jose City 1157RR

ELIGIBLE CLASSES AND ACTIVITIES:

Eligible Persons

- Students
  - Enrolled and registered,
  - while attending regularly scheduled classes at college; or
  - while attending college, supervised, and administratively approved activities, including club activities, or traveling under college supervision to and from college sponsored events.
- Student Athletes
  - Enrolled and registered,
  - while participating in or attending any regularly scheduled practice or competition supervised by an authorized representative of the college; or
  - while traveling directly to and from practice or competition with other members as a group,
  - provided such travel is supervised by an authorized representative of the college.
- Child(ren) of Students
  - while in or about the child care facility provided by the college, provided that the facility is on the college campus; or
  - while attending "Mommy and Me" classes provided by the college with their student parent, if applicable.
- High Risk Students
  - students who have paid the appropriate premiums, attending Fire or Police Academies associated with the college.

BENEFIT DEDUCTIBLES:

Per Accident Deductible

Student Activities Deductible $0

Class I Athletes Activities Deductible* $0

Class II Athletes Activities Deductible* $0

Child of Student in Child Care Facility Activities Deductible $0

*Class 1 Athletic Activities: football, soccer, wrestling, surfing, gymnastics and snow skiing; Class 2 Athletic Activities: all other sports.

NOTE: No deductible applies to Emergency Illness.

COVERAGE FOR ACCIDENT MEDICAL BENEFIT:

- In-Network PPO pays 100% excess medical expense.
- Out-of-Network PPO pays 50% of the maximum allowed amount.

Preferred Provider Organization (PPO) is a provider that has a contract with Anthem to provide services to insured persons.

Non-Preferred Provider Organization is a provider that has not agreed to provide services to insured persons.

SCHEDULE OF BENEFIT LIMITS:

Any benefit limits and benefit percentages for Accident Medical Expense Benefits apply, unless otherwise specified, on a per-Covered Person per-Covered Accident basis. Any applicable deductibles must be satisfied within the time period specified before benefits are payable.

- Outpatient physiotherapy and acupuncture: 100% covered for treatment at a PPO provider. $25 visit/treatment received from a non-PPO provider. Combined maximum number of visits: 24 per injury.
- Skilled nursing facility care: up to 100 days per accident.
- Home health services: up to 100 visits per accident.
- Prosthetic Devices: up to $1,000 per accident.
- Durable Medical Equipment: up to $2,000 medical necessity.
- Dental Injury: up to $2,000 per injury.

MAXIMUM ACCIDENT MEDICAL BENEFITS:

Students and Children of Students $50,000

Athletes $25,000

BENEFIT PERIOD:

52 weeks from the date of the accidental injury. First covered treatment must be incurred within 120 days from the date of the injury.

EMERGENCY ILLNESS BENEFIT:

For services authorized by policyholder $500 per accident.

COMMON EXCLUSIONS:

In addition to any benefit-specific exclusion, benefits will not be paid for any covered injury or covered loss which results as the proximate cause of any of the following unless coverage is specifically provided for by name in the Accident Medical Expense Benefits section.

- Services or supplies that are not medically necessary.
- Commission of or attempt to commit a felony or an assault.
- Commission of or active participation in a riot or insurrection.
- Bungee jumping, parachuting, skydiving, parasailing, and hang-gliding.
- Declared or undeclared war or act of war.
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline.
- Travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle.
- Participation in any motorized race or contest of speed.
- An accident if the insured person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license except while participating in Driver's Education Program.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Travel or activity outside the United States.
- The insured person's intoxication as determined according to the laws of the jurisdiction in which the covered accident occurred.
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.
- Any hospital stay or days of a hospital stay that is not medically necessary for the condition and locality.
- Services or treatment rendered by a physician, nurse or any other person who is employed or retained by the policyholder, living in the insured person's household, and who is a parent, sibling, spouse or child of the insured person. Services of relatives, professional services received from a person who lives in the insured person's home or who is related to them by blood or marriage.
- Experimental or investigative. Any experimental or investigative procedure or medication. But, if the insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review.
- Crime or nuclear energy. Conditions that result from: (1) the insured person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Any amounts in excess of the maximum allowed amount, the Maximum per Accident, or the Maximum per Emergency Illness.
- Services or supplies for the treatment of a pre-existing condition during a period of six months following the insured person's effective date.
- Voluntary payment, services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage.

A complete list of exclusions can be found in the policy.