INSURANCE MANAGEMENT SERVICES

AMARILLO INDEPENDENT SCHOOL DISTRICT

AMARILLO INDEPENDENT SCHOOL DISTRICT

Open Enrollment

Effective 07/01/2023

www.imstpa.com

Amarillo Independent School District Health Benefit Plan

Open Enrollment Period
Beginning: April 24, 2023

The open enrollment period for Amarillo Independent School District is here.

Eligible employees may enroll or drop coverage for themselves and/or eligible dependents.

All changes will become effective July 01, 2023.

In order to receive maximum benefits, please make every effort to choose a doctor or hospital who participates in the network via www.imstpa.com/findaprovider, or contact your Participant Advocates at 800-687-5944.

Who is IMS?

Insurance Management Services was formed in June 1983 with a mission of offering unequalled service for the self-insured health benefits market. Over the years, due to this commitment to excellence, our organization has continued to grow. We now have three companies providing administration service for over 42,000 covered lives.

Our companies, IMS Marketing, IMS Managed Care, and OMNI Networks provide turnkey administration service for our clients. Providing complete service in all areas enables us to be more efficient and cost effective for our clients and to properly and accurately respond to any situation which may arise. In addition, our web site, www.imstpa.com, allows employers, participants and providers immediate online access to plan and claim data. Thank you for choosing Insurance Management Services (IMS) for your insurance benefits needs.

INSURANCE MANAGEMENT SERVICES

INSURANCE MANAGEMENT SERVICES

Welcome to IMS

Claims Administrator

Insurance Management Services (IMS)
P. O. Box 15688
Amarillo, TX 79105

Customer Service

Phone 806-373-5944 or 800-687-5944
Fax 806-373-0995

Call your designated Participant Advocates:
Jennifer Moreno at 800-687-5944 ext 245; or,
Kat Vanderpool at 800-687-5944 ext 422

Monday / Wednesday / Friday
8:30 a.m.-5:00 p.m. (CST)
Tuesday / Thursday
8:30 a.m. - 9:00 p.m. (CST)

Provider Network

OMNI Networks
www.imstpa.com/findaprovider
The Preferred Provider Organization (PPO) will be OMNI Networks. In order to receive maximum benefits, please make every effort to choose a doctor or hospital who participates in the network via the above referenced websites or your Customer Service Representative.

IMS INSURANCE MANAGEMENT SERVICES

AMARILLO INDEPENDENT SCHOOL DISTRICT

WILL BE RECEIVING NEW ID CARDS EFFECTIVE JULY 1, 2023

Soon you will receive your NEW Member ID Card.

To avoid delay in services, prescription fills, and billing,
please make sure you present this new ID Card to:

- Doctors
- Hospitals
- Pharmacies

In order to receive maximum benefits, please make every effort to choose a doctor or hospital who participates in the network via www.imstpa.com/find-a-provider or contact your Participant Advocate.

Scan the QR code on your Member ID Card to gain access to your *Electronic* ID card. Here you will find details related to your copays, deductible, out of pocket, and other Health Plan materials.

Phone
806-373-5944

Website
www.imstpa.com

Email
PA@imsm.net

Participant Advocate Program

Your dedicated Participant Advocate welcomes you to IMS!

Insurance Management Services (IMS) is committed to providing you with a professional one on one experience. We developed our customized Participant Advocate Program to assist you and your dependents in understanding your benefits and the resources available to you. This program is designed to keep you connected with your individual Participant Advocate.

Your Participant Advocate (PA) specializes in understanding you and your employer and is here to help you navigate your Health Benefit Plan.

Your PA's primary goal will be to assist you with the following:

- Utilizing the Health Benefit Plan to its fullest potential
- Benefit coverage and claim status
- Locating providers
- Obtaining documentation necessary to process claims such as dependent verification, marriage certificates, claim form information, or medical records
- Comparing provider billing invoices with the explanation of benefits you receive from IMS
- Providing guidance when you are billed more than what our records indicate as patient responsibility

In order for the Participant Advocate Program to effectively work in your favor, we must be able to contact you when necessary. Please keep your employer and IMS updated with your most current contact information including cell, home, and work phone numbers, as well as your email address.

To ensure you have your PA's contact information easily accessible, please take a moment and add their contact information to your cell phone or other devices.

Our office hours are from:

8:30 a.m. to 5:00 p.m., Monday/Wednesday/Friday
8:30 a.m. to 9:00 p.m. Tuesday/Thursday

Contact your designated Participant Advocates:
Jennifer Moreno (Jennifer.Moreno@imsm.net) at 800-687-5944 ext 245; or,
Kat Vanderpool (Kat.Vanderpool@imsm.net) at 800-687-5944 ext 422

INSURANCE MANAGEMENT SERVICES

Understanding & Avoiding High Dollar Urgent Care

You have many options when considering what provider to see when dealing with similar medical situations. You can: See your primary care physician, visit an Urgent Care Clinic, head to a "Stand-alone" or "freestanding" ER, or a hospital affiliated Emergency Room. Depending on your location, both may be convenient options, and close by, with comparable wait times. All of these options can SEEM like they best for you.

BUYER BEWARE, "Stand alone" or "freestanding" Emergency Rooms ARE NOT In Network facilities, and ARE NOT billed the same as if going to an Urgent Care Clinic. These "ERs" will tell you they accept your insurance; however, they will bill you with rates similar to a hospital bill and will balance bill you for anything your insurance doesn't cover!

Get the BEST COST at these In Network Providers

BSA Urgent Care
4510 Bell St.
Amarillo, TX 79109
806-212-4835

CareXpress
2329 Ross Osage
Amarillo, TX 79103
806-350-5790

CareXpress
2701 S. Georgia
Amarillo, TX 79109
806-655-0522

Family Medicine Center
1500 Coulter St #6
Amarillo, TX 79106
806-467-9777

CareXpress
400 SW 14th Ave
Suite 100,
Amarillo, TX 79101
806-337-4555

CareXpress
7306 SW 34th Ave
Amarillo, TX 79121
806-350-3010

You'll spend MORE at these In Network ER's

Baptist St. Anthony Hospital
1600 Wallace Blvd
Amarillo, TX 79106
806-212-2000

ER on Soncy
3530 S. Soncy Rd.
Amarillo, TX 79124
806-340-0608

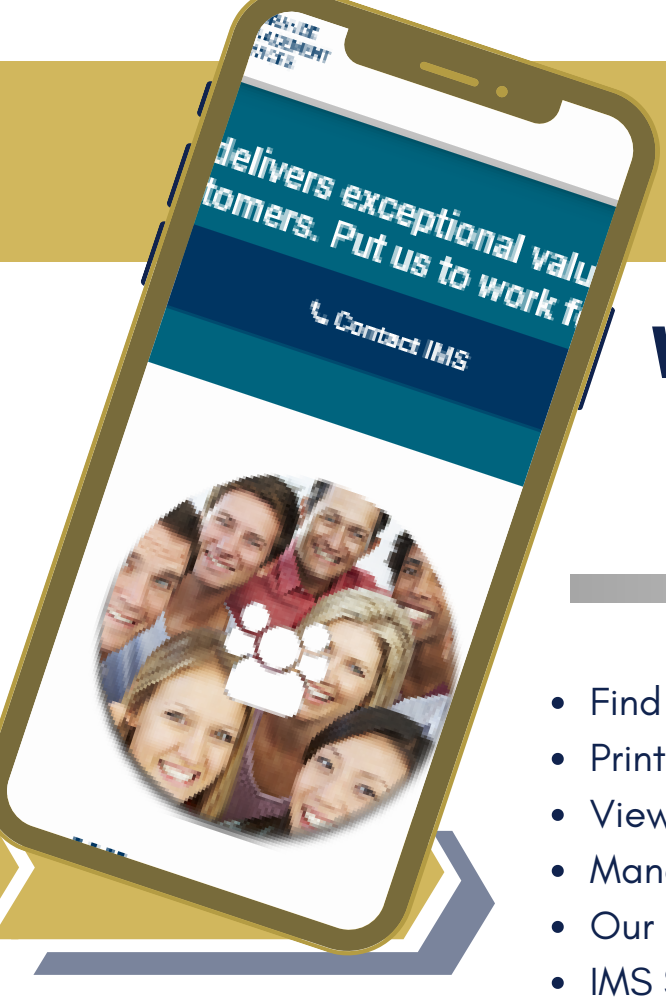
You'll spend THE MOST at these and other Out of Network ER's/Urgent Care Facilites

Northwest Texas Hospital

Northwest Emergency on Georgia

Exceptional Emergency Center

Northwest Urgent Care



IMS INSURANCE MANAGEMENT SERVICES

Welcome to our Website

The IMS website provides customer service at your convenience.

Available Features:

- Find a Provider
- Print Forms
- View ID Card
- Managed Care Services
- Our History & Services
- IMS Secure Mail
- Contact IMS via email
- Change your password
- Change your profile
- Claims & Coverage inquiry
- Request ID Card Copy
- Frequently asked questions

Follow the Steps below to Access the IMS Website

1. Go to www.imstpa.com
2. Click on Member
3. Click on Login
4. Click on New User Registration
5. Click on Register
6. Select your user type (either employee or dependent)
7. Enter your Group Number and any other additional information as required.
8. Enter the username you would like to use.
9. Employees will be asked to enter a password; dependents will be issued a password* when their account is approved.
10. Accept the "Terms" and click the "Submit" button

*We recommend that dependents change their password when they login for the first time.

Phone
806-373-5944

Website
www.imstpa.com

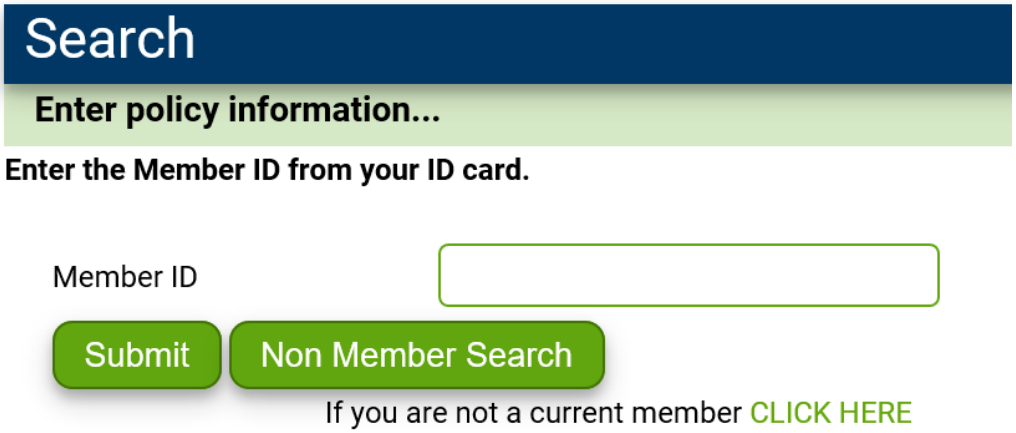
Email
PA@imsm.net

How to Find a Provider

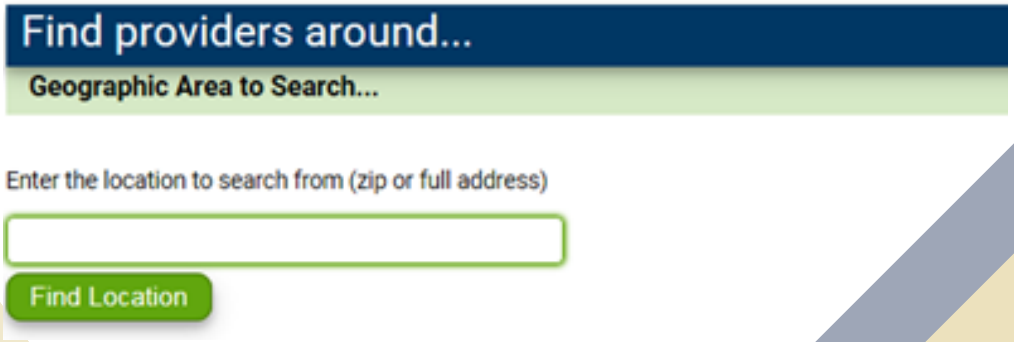
Please follow the steps below to locate a PPO Provider

- Visit the IMS Website at: www.imstpa.com.
- At the IMS home page, click "Member" hyperlink, and click on "Find a Provider".

- Enter your Group and Certificate information found on your IMS ID card; click submit. **Until your ID Card is received, select Non-Member Search**



- Enter Zip Code for the Geographic area you would like to search.

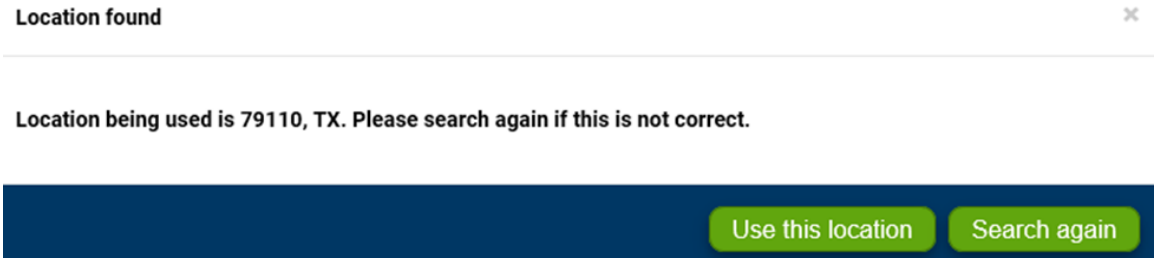


INSURANCE MANAGEMENT SERVICES

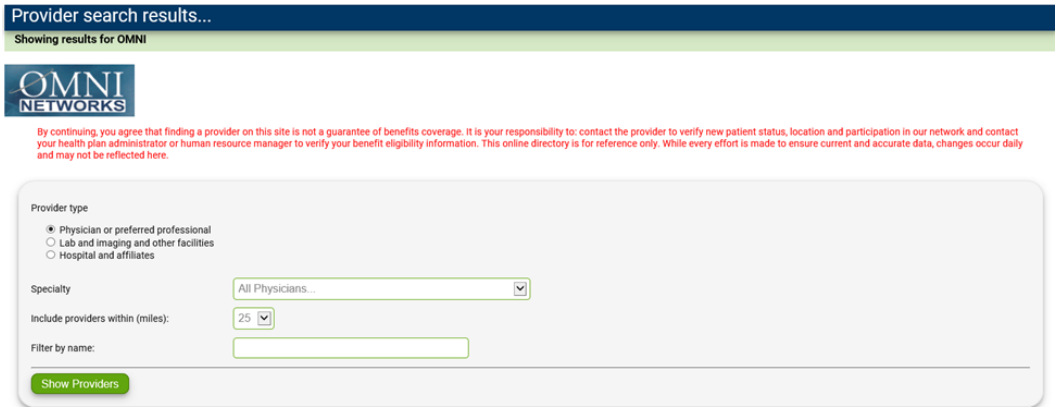
How to Find a Provider (cont.)

Please follow the steps below to locate a PPO Provider

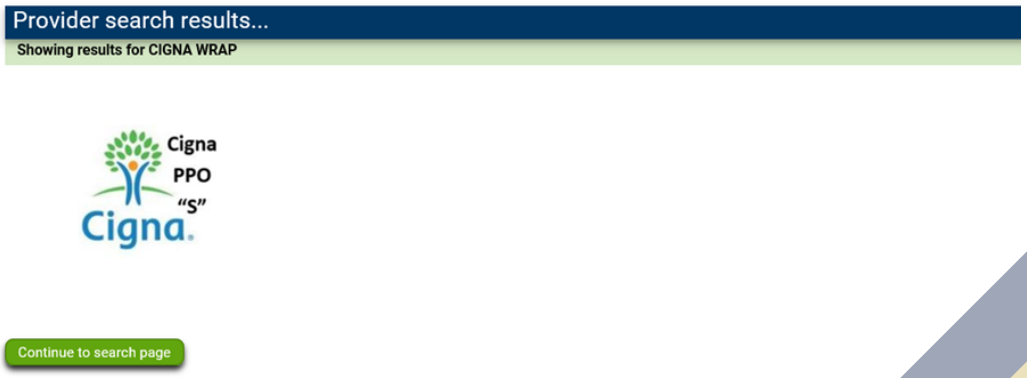
- Verify the search location.



- Inside the OMNI area you will be directed to search within the OMNI find a provider results. Use the search criteria to look for a provider. Providers that match your search criteria will be displayed.



- Outside of the OMNI area, the website will direct you to the Cigna Network. Click "Continue to search page".

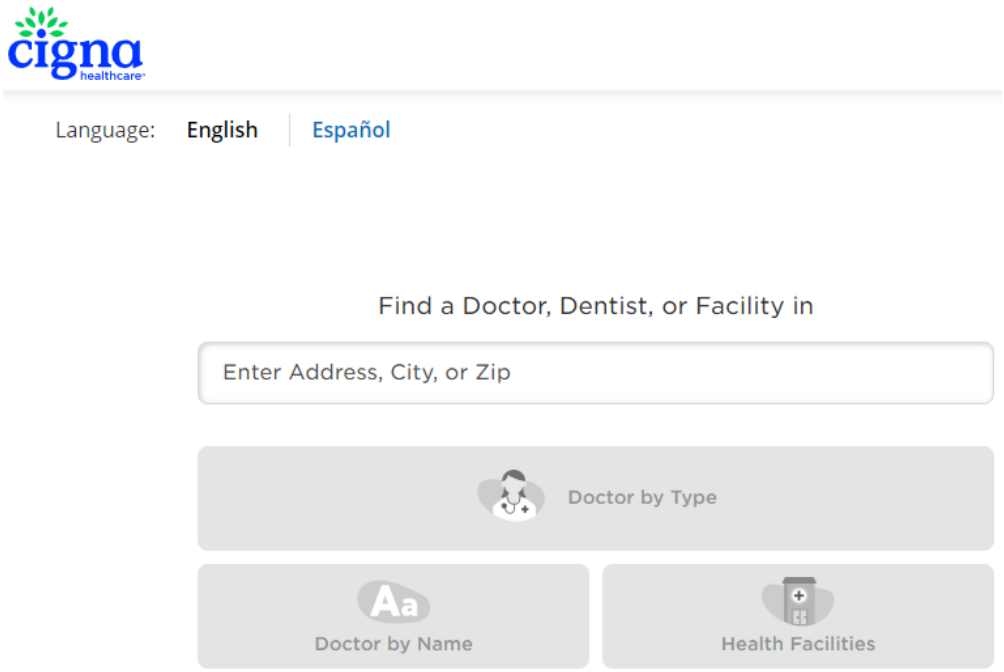


INSURANCE MANAGEMENT SERVICES

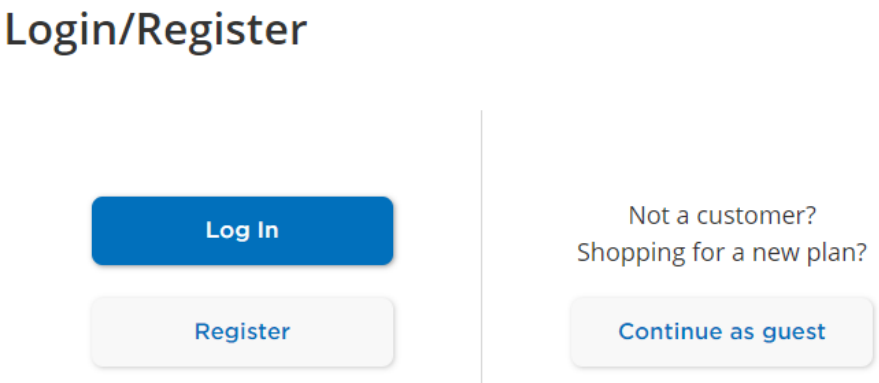
How to Find a Provider (cont.)

Please follow the steps below to locate a PPO Provider

- You will be redirected to the Cigna website. The search location can now be entered.



- Once you select how you would like to search for your provider, you will "Continue as guest".

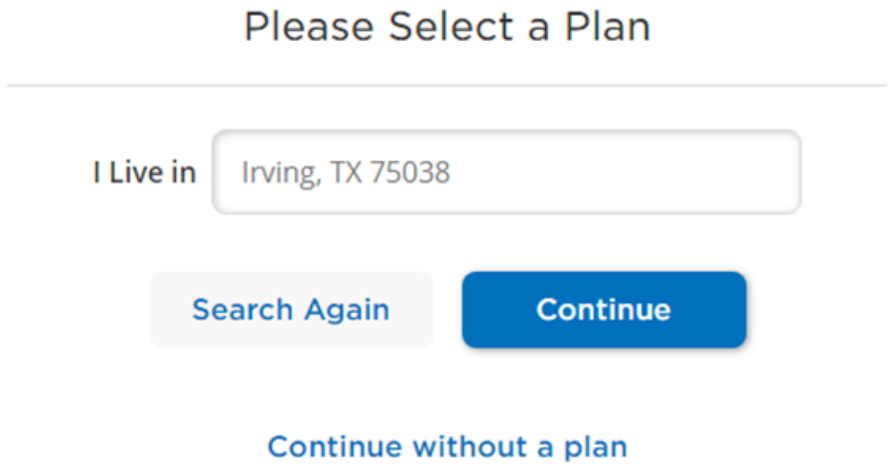


INSURANCE MANAGEMENT SERVICES

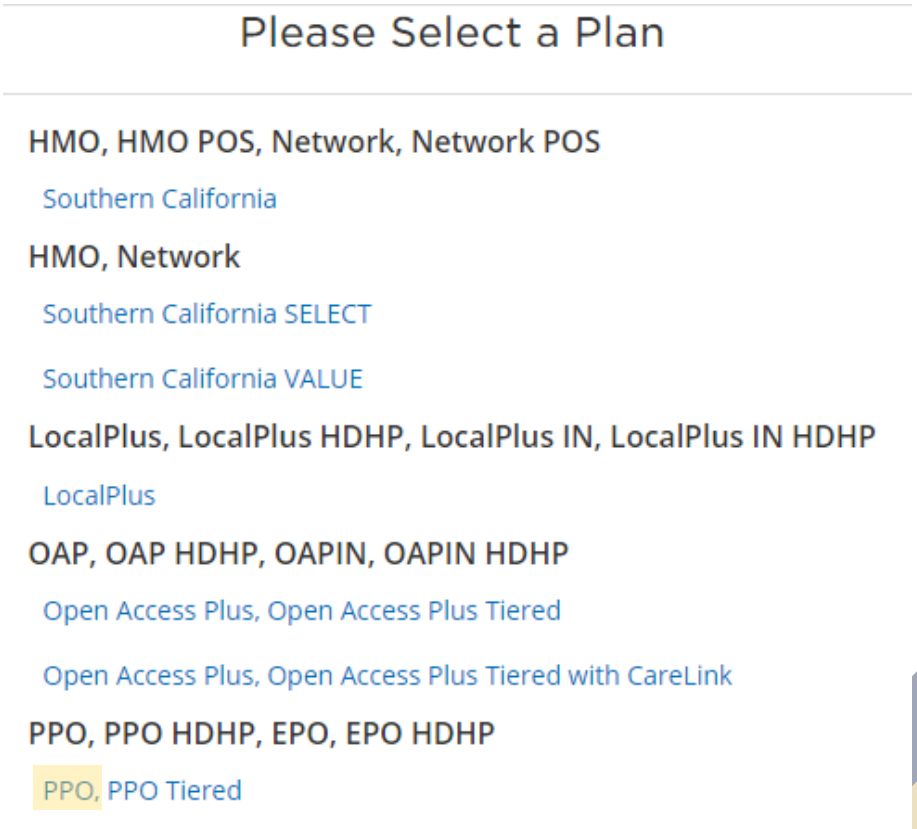
How to Find a Provider (cont.)

Please follow the steps below to locate a PPO Provider

- You will be directed to enter where you live. Enter the location where you are looking for care, and "Continue".



- Select “PPO”.



- Providers that match your search criteria will be displayed.

INSURANCE MANAGEMENT SERVICES

Forms to know and use

Enrollment Form

You will need to complete this form and elect coverage for you, your spouse, and/or children. Please sign and date the form. If you were provided a pre-populated change form, complete that in lieu of the enrollment form.

Dependent Verification Form

Please complete and sign only for covered dependents with a different last name than the participant.

Claims Form

You could possibly receive this form at the first of the year in order for IMS to update your information, gather additional details about a claim, or verify that you do not have additional coverage elsewhere.

Authorization Form

This authorizes IMS to release any and all necessary Protected Health Information to the person(s) you list on the form. This authorization remains valid for the term of coverage, unless specified in a written request. The participant must fill out this form in order to authorize another individual, other than themselves, to discuss claims, EOBs, or any other Protected Health Information concerning the participant and/or dependent(s) on this plan with IMS. This individual may be a spouse, parent, friend, etc.

Without a signed Authorization Form, the participant will be the only individual that IMS will release information to regarding the policy or the individual(s) on the policy.

Phone
806-373-5944

Website
www.imstpa.com

Email
PA@imsm.net

INSURANCE MANAGEMENT SERVICES

www.imstpa.com • P.O. Box 15688 • Amarillo, TX 79105

IMS Group Insurance Enrollment Form

EMPLOYEE INFORMATION: (to be completed by Employee)				EMPLOYMENT INFORMATION: (below section to be completed by Employer)	
Name:				Group Name:	Amarillo Independent School District
Address:					
City, ST, ZIP:				IMS Group Number:	SAISD00
Birth Date:		Marital Status:		Department:	
SSN:		Gender:	☐Male ☐Female	Date of FT Employment:	
Email:		Phone:		Effective Date:	

OTHER INSURANCE: *(If applicable, IMS will not pay claims until other insurance information is provided)*

Are you covered by other insurance, including Medicare?	☐Yes ☐No	*(If yes, please fill out the following information)*	
Insurance Carrier Name:			
Policy Number:		Phone Number:	

GROUP HEALTH COVERAGE OPTIONS:

Coverage	Health Plan Option Elected	Coverage Level
Medical	☐ PPO Plan ☐ CDHP Plan	☐Employee Only ☐Employee & Child(ren) ☐Employee & Spouse ☐Employee & Family
		Employees who elect coverage at the Employee Only level will receive one (1) ID card. All other coverage levels will receive two (2) ID cards.

SPOUSE INFORMATION:

Name:				Employer:		Carrier Name:	
Address:				Address:		Address:	
City, ST, ZIP:				City, ST, ZIP:		City, ST, ZIP:	
Phone:		Birth Date:		Phone:		Phone:	
SSN:		Gender:	☐Male ☐Female	Other Insurance:	☐ Medical	Policy No:	

DEPENDENT INFORMATION: *(complete this section for all dependents you want covered)*

No.	Name	SSN	Relationship to Insured	Birth Date	Gender	Other Insurance *(including Medicare or Medicaid)*:
1.					☐Male ☐Female	☐Yes ☐No
	Name of Other Insurance Carrier:		*Policy Number:*		*Phone Number:*	
2.					☐Male ☐Female	☐Yes ☐No
	Name of Other Insurance Carrier:		*Policy Number:*		*Phone Number:*	
3.					☐Male ☐Female	☐Yes ☐No
	Name of Other Insurance Carrier:		*Policy Number:*		*Phone Number:*	
4.					☐Male ☐Female	☐Yes ☐No
	Name of Other Insurance Carrier:		*Policy Number:*		*Phone Number:*	

EMPLOYEE AUTHORIZATION:

I AUTHORIZE any physician, dentist, medical practitioner, hospital, pharmacy or other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to Insurance Management Services or my employer all information and records relating to diagnosis, treatment, medical history, physical or mental condition and evaluation, or any other information relating to me, my spouse, or my dependent children. I understand that any information obtained will not be released to any person or organization except re-insurers, other persons or organizations performing business or legal services in conjunction with my coverage, or as required by law, or as I may authorize. A photocopy of this authorization remains valid for the term of coverage. I have the right to receive a copy of this authorization upon request.

Employee Signature:		Date:	

REFUSAL OF GROUP HEALTH COVERAGE

This is to certify that I have been given an opportunity to apply for group health coverage available to me through my Employer, and I have decided not to apply coverage for:
☐Myself ☐Spouse ☐Child(ren)

Reason for Refusal: ☐Other Coverage ☐Other Reason (specify):

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in this Plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

Employee Signature:		Date:	

INSURANCE MANAGEMENT SERVICES
VERIFICATION OF DEPENDENT ELIGIBILITY
(PLEASE FILL OUT ENTIRE FORM)

In order to verify eligibility on your dependent we need the following information. Until this information is received along with any necessary documentation, we will be unable to process any claims for this dependent. If we must deny a claim, it can only be reprocessed with a written appeal. Please provide proper documentation within 30 days.

Employee's Name: _____

Dependent's Name: _____

Dependent's Natural Mother

Name: _____

Address: _____

Employer: _____

Employer Phone Number: _____

Dependent's Natural Father

Name: _____

Address: _____

Employer: _____

Employer Phone Number: _____

1. The natural parents are: _____ Married _____ Divorced _____ Separated _____ Mother Deceased

   _____ Father Deceased _____ Never married _____ Other _____

2. Dependent's relationship to the employee: _____ Natural Child _____ Stepchild (Birth Certificate)

   _____ Other (Explain) _____

3. If the dependent is not a natural child of the employee, on what date did the child become dependent on him/her?

   _____

4. Does the dependent live with the employee? _____ Yes _____ No

5. Is the dependent employed on a full-time basis? _____ Yes _____ No

6. Is the dependent a full-time student? _____ Yes _____ No

   If Yes, please provide full-time student verification from the registrar of your dependent's school.

7. Do you or any of your dependents have other insurance? _____ Yes _____ No

   If yes, name of person(s) insured: _____ Policy Number: _____

   Name of Other Insurance Company: _____

   Phone Number: _____

8. If the natural parents are divorced/unmarried, is there a divorce decree/child support order that establishes who is responsible for the coverage of the dependent? _____ Yes _____ No

   If Yes, please provide a copy of the first page of the divorce decree/child support order and any subsequent pages that detail who is responsible for coverage of the dependent. Even if the dependent has other coverage, he/she may still be covered under this plan. The divorce decree/child support order is used to determine primary and secondary payer responsibility.

Please Note: Approval of this verification cannot be extended indefinitely. It may become necessary to request another form in order to determine that the dependent's status has not changed.

I represent that the above answers and statements are true and complete to the best of my knowledge. I understand that the statements made above will be used to verify that the dependent named above is eligible for coverage in accordance with the definition of the dependent as stated in the group plan under which I am covered.

Employee Signature: _____ Date: _____

Employee Social Security Number: _____

INSURANCE MANAGEMENT SERVICES
(806) 373-5944 • 1-800-687-5944
www.imstpa.com • P.O. Box 15688 • Amarillo Tx 79105

CLAIM INFORMATION FORM

IMS will not pay claims until Other Insurance Information is provided.
Other Insurance Information must be collected every 12 months.

Instructions Complete required information* and submit form in any of the following ways:

IMS Website https://imstpa.com/forms/ClaimInfo.pdf
By fax to: 806-373-0995
By Email: PA@imsm.net
Print, Mail to: IMS, PO Box 15688, Amarillo TX 79105

1. **Employee Information***

IMS Policyholder / Employee Name _____ Date of Birth ____/____/____

Employer Name: _____

Member ID or last 4 of SSN _____ Phone # _____ Email _____

2. **Other Coverage Information***

Have you, your spouse, or any dependents covered under this IMS plan had any other Medical, Dental, Vision, Medicaid, or Medicare coverage? * ☐ Yes ☐ No

If marking YES to other coverage, please provide a copy of all other Insurance Cards AND complete the below for all members covered on policy.

Policyholders Name_____ Date of Birth ____/____/____
Name of other Insurance carrier _____
Policy # _____ Group# _____ Insurance Carrier Phone # _____
Name and Relationship to policyholder for all covered under this policy _____
_____
_____

Policyholders Name_____ Date of Birth ____/____/____
Name of other Insurance carrier _____
Policy # _____ Group# _____ Insurance Carrier Phone # _____
Name and Relationship to policyholder for all covered under this policy _____
_____
_____

If other coverage is Medicare, please provide the below information for all Medicare participants

Member Name_____
☐ Part A Effective Date ____/____/____
☐ Part B Effective Date ____/____/____
☐ Part D Effective Date ____/____/____

Reason for Medicare coverage:
☐ Age 65 or older
☐ Disabled
☐ End Stage Renal Disease (ESRD)
Date dialysis treatment began ____/____/____

3. **Accidental Details and/or On the Job Injury, only complete if applicable:**
   - **a.** Do you, your spouse or your dependents have current claim that is due to an injury? ☐ Yes ☐ No
   - **b.** Do you or your dependents have a current claim that occurred in the course of employment? ☐ Yes ☐ No

If yes, please explain accident/injury and provide date of injury and where injury occurred.

_____
_____

_____ _____ _____
Employee/Policy Holder Signature Patient's Signature Date

INSURANCE MANAGEMENT SERVICES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Participant Name: _____
Address: _____
_____
Date of Birth: _____/_____/_____
Social Security Number: _____-_____-_____
The Plan: _____

This Authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

I,_____, am a participant in the above referenced Plan, and hereby authorize the use or disclosure of my Protected Health Information as described in this Authorization.

1. Specific person(s)/organization authorized to provide the Information.

   Insurance Management Services

2. Specific person(s)/organization authorized to receive and use the Information.

   _____
   _____
   _____

3. Specific description of the Information to be used and/or disclosed.

   ☐ Any and all Protected Health Information;

   OR

   ☐ (please describe): _____
   _____

I, _____, hereby understand the following:

4. Right to revoke: I understand that I have the right to revoke this Authorization at any time by notifying the appropriate entity, in writing. I understand that the revocation is only effective after it is received. I understand that I cannot revoke this authorization to the extent that action has been taken in reliance of this authorization (for example, any use or disclosure made prior to the revocation under this Authorization will not be affected by the revocation).

5. I understand that after the information that is the subject of this Authorization is used or disclosed, the Privacy Standards may not protect it and the recipient may re-disclose it.

6. I understand that this Authorization is not required for disclosures related to treatment, payment and/or health care operations, or if the use or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.

7. I understand that I am entitled to receive a copy of this Authorization.

8. I understand that this Authorization will automatically renew at the beginning of each calendar year unless otherwise revoked pursuant to the provisions outlined in paragraph 4 above.

_____ _____
Date Individual