NORTH CAROLINA SCHOOL BOARDS TRUST ("NCSBT") NO-FAULT MEDICAL EXPENSE COVERAGE

Please read this entire document carefully.

The Board's Errors & Omissions/General Liability Coverage Agreement ('Coverage Agreement") with NCSBT includes an endorsement for no-fault medical expense coverage ("medical expense"). The medical expense endorsement to the Coverage Agreement contains the complete terms of the Board's medical expense coverage with NCSBT, including any *specific conditions and/or exclusions that may cause your claim to be denied.*

A claim made under the medical expense endorsement does not trigger liability coverage under the Board's Coverage Agreement.

- **This medical expense coverage has a firm one-year deadline.** This coverage only applies to medical expenses incurred *within one year of the occurrence* that caused the accidental injury. Your complete Medical Expense Certificate *must be submitted to the school district within one year of the occurrence* that caused the accidental injury. The date submitted to the school district is considered the date submitted to the NCSBT for purposes of the one-year deadline. *If you do not timely submit the complete Medical Expense Certificate, your claim will be denied.*
- The coverage limit is **$2,500 per person*/coverage period,** subject to the per occurrence limit and coverage period aggregate contained in the medical expense endorsement. *(For accidental injury on or after July 1, 2024, a $1,000 dental sublimit applies.)
- This coverage is **excess over all insurance or other benefits (except Medicare).** This means NCSBT will not make any payments unless and until all other claims are fully and finally processed with any insurance company or other coverage that may apply, including health insurance, accident coverage, and student athletic coverage.

I. HOW TO FILE A MEDICAL EXPENSE CLAIM

1. **READ CAREFULLY AND FULLY COMPLETE** Part II of the Medical Expense Certificate. If you have questions, contact NCSBA Litigation Assistant Melody Coons at mcoons@ncsba.org or (919) 747-6684.
2. **ATTACH** all itemized, updated medical bills, Explanation of Benefits Statements, and all other information that the Medical Expense Certificate requires. You may have to request current or updated statements and bills from medical providers or others so you can submit them with the Medical Expense Certificate.
   - Updated, itemized bills and Explanation of Benefits statements show NCSBT what has been paid and who has paid it, so NCSBT can properly determine the amounts that are owed to each person or provider. *NCSBT will not make any payments if the Medical Expense Certificate is incomplete and/or we do not have all current updated, itemized medical bills.*
   - NCSBT cannot determine whether you are entitled to medical expense benefits until *after* you fully submit your claim. *Your claim may be denied once it is submitted if it does not meet the coverage requirements that are set forth herein or in the Board's medical expense endorsement.*
3. **COMPLETE** Attachment A (and Attachment B if necessary).
   - If the injured person does not have or refuses to provide the last five digits of his or her Social Security Number ("SSN"), he or she (or the parent or legal guardian of the injured person) ***must COMPLETE Attachment B.*** NCSBT must have this information to comply with federal law. If you do not provide the last five digits of the injured person's SSN and do not complete Attachment B, *your claim will be denied.* (If you provide the last five digits of the injured party's SSN, you do not have to complete Attachment B.)
4. **DOUBLE-CHECK** to make sure that you have *fully completed* your Medical Expense Certificate and that you have *attached all of the information* it asks for, *including up-to-date, itemized medical bills.*
5. **SIGN** the completed Medical Expense Certificate before a notary.
6. **SUBMIT** the completed Medical Expense Certificate along with the Attachment(s) and necessary documentation to the Superintendent or his or her designee. *If you do not submit the complete Medical Expense Certificate to the school district before the one-year deadline expires, your claim will be denied.*
7. **CURE ANY DEFECTS.** Once the school district has submitted your Medical Expense Certificate to NCSBT, you will be notified if your documentation is incomplete and what additional information or documentation is needed. ***All additional information and documentation must be submitted to NCSBT within two months after the one-year deadline expires.*** Any information or documentation submitted after those additional two months *will be disregarded.*

KEEP IN MIND--

- The accidental injury that is the subject of your claim *must have been reported to the Superintendent or his or her designee within 30 days* of the occurrence that caused the accidental injury.
- The injured party and parent or legal guardian of the injured party must cooperate in the investigation of the claim. At NCSBT's request and expense, the injured party must submit to examinations by physicians of NCSBT's choice.

II. MEDICAL EXPENSE CERTIFICATE

TO BE COMPLETED BY INJURED PARTY OR, IF A MINOR, BY THE MINOR'S PARENT OR GUARDIAN

NOTICE TO INJURED PARTY OR PARENT/GUARDIAN: This form must be submitted to the Member School District within one year of the occurrence that caused the accidental injury, with all required documentation and Attachment(s). Failure to provide complete information will affect recovery of benefits. Once you have fully completed the Medical Expense Certificate and attached all required documentation, sign this Medical Expense Certificate before a notary and submit it to the Superintendent or his or her designee, along with your completed Medical Expense Certificate Delivery Certification.

The Superintendent or designee must complete page 7 and forward this form and all necessary documentation to the North Carolina School Boards Trust ("NCSBT"). *See additional instructions on page 7.*

Accident/Injury Information

1) Injured party's name: First _____ Middle _____ Last _____

   Address: _____

   Gender: ☐ M ☐ F Date of Birth: ____/____/_____ Last five digits of SSN: _____

   NOTE: If the injured party does not have an SSN or refuses to provide the last five digits of his/her SSN, you MUST complete Attachment B. Failure to provide the last five digits of the injured party's SSN or complete Attachment B will result in a denial of benefits under this coverage.

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

   E-mail Address: _____

2) If injured party is a minor, the minor's parent or legal guardian should complete the following:

   Name of Parent (or Legal Guardian): _____

   Address: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

   E-mail Address: _____

3) Date of occurrence: _____

4) School where occurrence happened: _____

   School District where occurrence happened: _____

5) Statement of Facts: Tell in your own words exactly what happened. Please attach a separate page if necessary.

   List of witnesses to occurrence (if there are additional witnesses, please list on a separate page and attach):

   Name of Witness: _____

   Witness Address/Phone: _____

   _____

   Name of Witness: _____

   Witness Address/Phone: _____

   _____

6) Description of Injury:

7) Is treatment complete? ☐ Yes ☐ No

Insurance/Benefits Information

8) Is the injured person covered under health or medical insurance coverage? ☐ Yes ☐ No

If yes: Name and address of health or medical coverage insurance company: _____

_____

Phone: _____

Name of Insured/Covered Person: _____

Policy Number: _____ Group Number: _____

Plan Number: _____

9) Is the injured person covered under dental insurance coverage? ☐ Yes ☐ No

If yes: Name and address of dental coverage insurance company: _____

_____

Phone: _____

Name of Insured/Covered Person: _____

Policy Number: _____ Group Number: _____

Plan Number: _____

10) Is the injured person eligible for the following?

Medicaid ☐ Yes ☐ No Medicare ☐ Yes ☐ No If yes, HICN or MBI _____

Other Government Medical Assistance Benefits: ☐ Yes ☐ No

If yes, identify: _____

11) Is the injured person a student enrolled in the Member School District? ☐ Yes ☐ No

If yes, is the injured person covered under any student accident and/or athletic coverage purchased by the parent or guardian through the Member School District? ☐ Yes ☐ No

If yes: Name and address of insurance company: _____

_____

Phone: _____

Policy Number: _____

Coverage Limit For Covered Claims

The coverage limit for covered claims is $2,500 per person*/coverage period, subject to the Member School District's per occurrence limit and coverage period aggregate. *(For accidental injury occurring on or after July 1, 2024, a $1,000 dental sublimit applies.) Medical Expense Certificates seeking reimbursement/payment in excess of the applicable coverage limit will not be considered until revised and resubmitted within the applicable coverage limit.

Excess Coverage

This coverage is excess over any other benefits available for the Accidental Injury, including but not limited to the injured party's health insurance (with the exception of Medicare) and any student accident and/or athletic coverage. No benefits will be paid under this program in circumstances where other insurance/coverage is applicable and/or pending.

Required Medical Documentation

This section of the Medical Expense Certificate must be fully completed in order for your claim to be considered. Any corrections or additional information necessary to cure an incomplete Medical Expense Certificate must be submitted to NCSBT within two months of the expiration of the one-year deadline to file a claim.

Provide all information required below regarding all medical expenses for which you are seeking reimbursement/payment (*i.e.*, expenses not covered under the insurance, plans, or benefits programs identified above). **You must provide updated, itemized medical provider statements which reflect date(s) of service, services rendered, International Classification of Diseases diagnostic codes (ICD-10 diagnostic codes), charges for services, payments, and any outstanding balances.** You must also provide all applicable Explanation of Benefit statements. If additional space is needed, please list on a separate page and attach. "See attached" is not an acceptable response to this section:

- Provider Name: ____

  Date(s) of Service: ____

  Medical Services Rendered: ____

  Original Amount of Bill: $___________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

- Provider Name: ____

  Date(s) of Service: ____

  Medical Services Rendered: ____

  Original Amount of Bill: $___________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

- Provider Name: ____

  Date(s) of Service: ____

  Medical Services Rendered: ____

  Original Amount of Bill: $___________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

- Provider Name: ____

  Date(s) of Service: ____

  Medical Services Rendered: ____

  Original Amount of Bill: $___________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

- Provider Name: ____

  Date(s) of Service: ____

  Medical Services Rendered: ____

  Original Amount of Bill: $___________

  Total Amount Claimed for Payment to Provider of Outstanding Balance: $_____________

  Total Amount Claimed for Reimbursement of Out-of-Pocket Expense: $_____________

I, _____, hereby certify that the information provided on this Medical Expense Certificate and the attached documentation represent all true, correct, current, and up-to-date information supporting this claim, and I have completed this form and provided such documentation to the best of my ability.

This the _____ day of _____, 20_____.

This form must be signed by the injured party or, if the injured party is a minor, by the injured party's parent or guardian. Forms that are signed by anyone other than the injured party or, if appropriate, the injured party's parent or guardian will be returned for the required signature.

_____
Signature

_____
Print Name

NORTH CAROLINA
COUNTY OF _____

I, _____, a Notary Public of the County and State aforesaid, do certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this the _____ day of _____, 20_____.

_____
Notary Public

_____
Print Name

My Commission Expires: _____

PLEASE COMPLETE PAGE 6, MEDICAL EXPENSE CERTIFICATE DELIVERY CERTIFICATION, TO CONFIRM DELIVERY OF YOUR MEDICAL EXPENSE CERTIFICATE.

MEDICAL EXPENSE CERTIFICATE DELIVERY CERTIFICATION

Please note that the injured party (or his or her parent/guardian) is responsible for ensuring timely submission of a completed Medical Expense Certificate. Your complete Medical Expense Certificate *must be submitted to the school district within one year of the occurrence* that caused the accidental injury. Failure to timely submit a Medical Expense Certificate will result in denial of your claim.

Please certify below that you have delivered your completed Medical Expense Certificate to the school district, including the method and date of delivery.

Method of Delivery	Date of Delivery
☐ Hand delivered to _____	_____
☐ Sent via email to _____	_____
☐ Faxed to _____	_____
☐ Sent via registered mail to _____	_____

_____
Signature of injured party or person certifying delivery

For your protection, especially for claims being submitted close to the one-year deadline, you should retain a copy of the documentation that confirms the date the completed Medical Expense Certificate was delivered to the school district (e.g., the email, fax confirmation, or mail return receipt).

For hand delivery, please ask the school district employee to whom the Medical Expense Certificate is delivered to sign below.

CONFIRMATION OF HAND DELIVERY

The signature below confirms that the Medical Expense Certificate for _____ (name of injured party) was hand-delivered on _____ (date).

The signature below does not confirm that the Medical Expense Certificate is completed fully or accurately, nor does it confirm that the claim will be covered under the terms of the Board's medical expense coverage.

_____
Signature of school district employee accepting the Medical Expense Certificate

_____
School district employee's title

This form must be submitted by the school district to NCSBT.

TO BE COMPLETED BY THE MEMBER SCHOOL DISTRICT:

The Member School District should answer the following questions, have this page signed by the Superintendent or his or her designee, and consult the steps listed below before sending this Medical Expense Certificate to NCSBT.

Does the school district purchase student accident insurance for all of its students? ☐ Yes ☐ No

Does the school district purchase athletic coverage for its middle school students who participate in athletics? ☐ Yes ☐ No

Does the school district purchase athletic coverage for its high school students who participate in athletics? ☐ Yes ☐ No

If the school district does purchase athletic coverage for middle and/or high school athletics, is the coverage catastrophic coverage only? ☐ Yes ☐ No If the coverage is catastrophic coverage only, at what amount is the coverage triggered? $_____

_____
Signature of Superintendent or Designee

_____
Print Name

_____
Title

_____
Date

THE FOLLOWING ITEMS MUST BE SUBMITTED TO NCSBT:

- Completed Medical Expense Certificate Delivery Certification
- Fully completed and executed Medical Expense Certificate
- Attachment A (and Attachment B if necessary)
- Itemized, updated medical documentation to support each and every claimed amount
- All accident or incident reports prepared by the Member School District
- Summary of all specific details known to the Member School District regarding the Accidental Injury

Submit all of the above to the attention of Melody Coons at claims@ncsba.org.

ATTACHMENT A

HIPAA Privacy Authorization Form

(Authorization for the use or disclosure of protected health information, required by the Health Insurance Portability and Accountability Act, 45 C.F.R. §§ 160, 164.)

I,_____, on behalf of _____ ("Patient"), authorize Patient's healthcare providers to use and disclose the protected health information described below to the North Carolina School Boards Trust. This authorization for release of information covers all past, present, and future periods.

I authorize the release of Patient's complete health record: **(Circle A or B.)**

A. including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of drug or alcohol abuse; OR
B. with the exception of the following information: (Circle one or more of the following options.)
    a. Mental health records.
    b. Communicable diseases, including HIV and AIDS.
    c. Alcohol/drug abuse treatment.
    d. Other (please specify): _____.

The North Carolina School Boards Trust may use this medical information for billing or claims payment or other purposes as I may direct. This authorization shall be in force and effect until one year from the date of signing, at which time this authorization expires. I understand that I may refuse to sign this authorization and that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent any person or entity has already acted in reliance on my authorization. I understand Patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand information used or disclosed pursuant to this authorization may be disclosed by the North Carolina School Boards Trust and may no longer be protected by federal or state law.

_____
Signature of Patient or personal representative

_____
Printed name of Patient or personal representative and his or her relationship to the patient

_____
Date

As noted in the instructions and on page 3, only those injured parties who do not have an SSN or refuse to provide the last five digits of their SSN must complete and submit this form. If the last five digits of the injured party's SSN was provided on page 3, this form is not required.

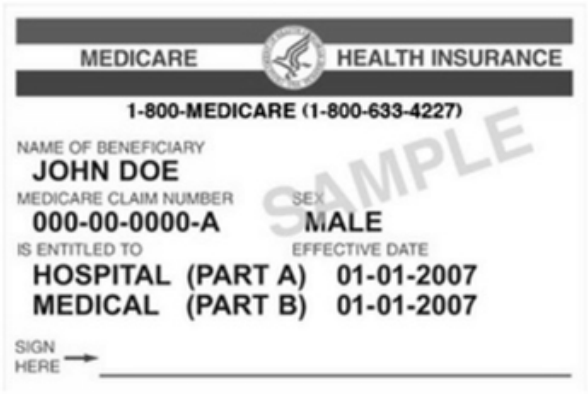
ATTACHMENT B

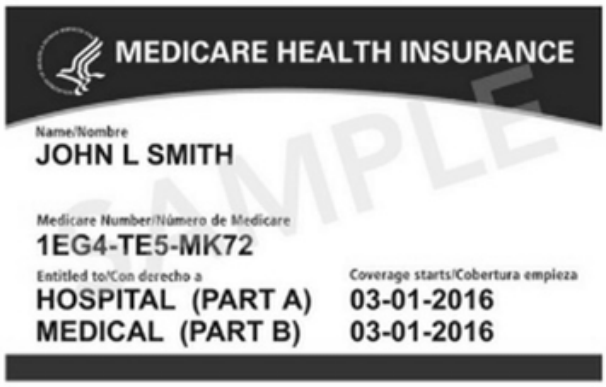
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance or coverage in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance or coverage. However, if certain other insurance or coverage delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance or coverage pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability coverage providers and insurers (including self-insurers), no-fault coverage providers and insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance or coverage. This reporting is to assist CMS and other insurance and coverage plans to properly coordinate payment of benefits among plans so that claims are paid promptly and correctly.

Please answer the questions below so that NCSBT may comply with this law.

Note: If the injured party has or has ever had a Medicare card similar to one or both of the cards pictured below, the injured party has been enrolled in Medicare.





Section I

Is the injured party presently, or has the injured party ever been, enrolled in Medicare? ☐ Yes ☐ No

Has the occurrence that caused the accidental injury been reported to Medicare? ☐ Yes ☐ No

If yes, please provide the Medicare claim number: _____

Section II

I understand that the injured party's full name, date of birth, partial SSN, Medicare enrollment status, and Medicare claim number have been requested to assist NCSBT in accurately coordinating benefits with Medicare and in meeting its mandatory reporting obligations under Medicare law.

_____
Printed name of injured party

_____
Printed name of parent or guardian, if injured party is a minor

_____
Signature of injured party (if a minor, signature of parent or guardian)

_____
Date

Section III

For the reason(s) listed below, I have not provided the last five digits of the injured party's SSN. I understand that if the injured party is a Medicare beneficiary and I do not provide the requested information, myself and/or the injured party may be violating my/our obligations to assist Medicare in coordinating benefits to pay claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____	_____
Printed name of injured party	Printed name of parent or guardian, if injured party is a minor
_____	_____
Signature of injured party (if a minor, signature of parent or guardian)	Date

Clear All Fields