

EXCESS ACCIDENT MEDICAL EXPENSE INSURANCE *CLAIM REQUIREMENTS & GUIDANCE*

Insurance information is necessary to expedite treatment and payment of all medical claims incurred from injuries from participation in intercollegiate sport activities. If the student has any other insurance coverage, this primary coverage must pay its normal benefit before the Excess Accident Medical Expense Insurance considers benefits on a secondary basis. It is the student responsibility to file his/her own claim with his/her personal medical insurance company. If covered under a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), the student should follow the rules of that plan including using specific facilities when appropriate.

CLAIM SUBMISSION REQUIREMENTS

- **Completed Claim Form**
 - Must be completed in full and signed by the student and/or appropriate school official where applicable.
 - A separate claim form is required for different unrelated injuries.
 - Should detail accident information (i.e. part of the body injured, how the injury occurred, etc.).
 - Please have the student complete all necessary portions of the form, sign and date the claim form.
- **Description of incident** (if not provided elsewhere)
- **Operative/ Physician notes** for any and all surgeries or visits
- **Medical bills** (industry standard forms HCFA1500 or UB92/UB04)
 - Attach itemized copies of all bills, including those bills under any deductible your plan may have. Also, include those bills paid partially or in full by other insurance.
 - Bills showing only "Balance forward" or "Balance due" are not sufficient.
 - An itemized bill indicates the provider of service's full name and mailing address, type of service, date of service, fee charged and diagnosis codes.
- **Explanation of Benefits (EOB)** from the student's primary health insurance ("other insurance").
 - An EOB should correspond to all Medical Bills.
 - If any benefits are denied by other insurance, please provide a copy of the denial showing the reason charges were denied (Include front and back of explanation of benefits when necessary).
 - To assure quick processing, please be sure that the bill and EOBs submitted are for the same item.



Generally, these items will be sufficient to complete a claim determination, but occasionally additional information will be required on a case-by-case basis.

CLAIMS ADMINISTRATOR
BMI BENEFITS , LLC
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PLAN HIGHLIGHTS AND NOTABLE LIMITATIONS

- The maximum benefit is **\$20,000 per covered accident**.
- First covered expenses must be incurred within **60 days** from the date of the covered accident.
- **Physician surgical expenses limitation** - If an Injury requires multiple surgical procedures through the same incision, the plan will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, the plan will pay for the most expensive procedure and 50% of covered expenses for the additional surgeries.

Accident Medical Expense Benefits are only payable:

- 1) for Usual and Customary Charges;
- 2) for those covered expenses incurred by or on behalf of the Covered Person;
- 3) for covered expenses required to treat an Injury and prescribed or ordered by a Physician;
- 4) for Covered expenses incurred within **90 days** after the date of the Covered Accident.

Coverage applies for Policyholder Supervised & Sponsored Activities

The Covered Person must be:

- 1) on the premises of the Policyholder:
 - a) during its normal hours;
 - b) during scheduled functions; and
 - c) during other periods if he/she is attending or participating in a Supervised and Sponsored Activity.
- 2) not on the Policyholder's premises and attending or participating in a Supervised and Sponsored Activity;
- 3) traveling directly, without interruption:
 - a) between the site of the Supervised and Sponsored Activity and the Policyholder's premises, if the Supervised and Sponsored Activity is located within or outside the town where the Policyholder's premises are located.
 - b) in a vehicle which is:
 - i. designated or furnished by the Policyholder;
 - ii. operated by a properly licensed, adult driver; or
 - iii. under the direct supervision of the Policyholder; or
 - c) in a vehicle other than that described in (3)(b) when:
 - i. operated by a properly licensed driver; and
 - ii. travel time does not exceed two hours each way.

ADDITIONAL TERMS, CONDITIONS, EXCLUSIONS AND LIMITATIONS DO APPLY.

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GENERAL INFORMATION

- All charges for the student must be submitted through the primary medical plan first (assuming they have primary coverage).
- Discounts through medical networks will not apply for claims that have previous discounts applied.
- Please use a binder/paper clip to keep individual documents together (no staples)
- It is helpful to clearly identify each bill with the amount owed by the insured, if it is different from the amount charged.
 - This is not necessary for charges that include an EOB (since the EOB will show the patient amount due), but is directed more towards bills where there was an arrangement including a private discount with a provider.
- If you use an internal account sheet for each injury that lists the provider, charged amount, and the amount paid by the school, it may be useful to include a copy with your filing.
 - This is not necessary, but it can help the process.

What is "Other insurance"?

Other Insurance means all other valid and collectible hospital, medical, dental, or surgical or disability insurance, providing benefits for losses of the kind described in the policy, whether provided in the form of services or cash payments, whether on an indemnity basis or on a provision of service basis, under any other individual, group, blanket or franchise insurance policy, certificate or contract, hospital or medical service program, or group practice prepayment plan.

What is an EOB?

EOB stands for Explanation of Benefits. EOBs are necessary to properly administer excess insurance benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is paid, denied, or pending) to a medical claim processed on your behalf. If no other insurance applies, there will be no EOB, however, this must be indicated to the claims processing firm.

What is a HCFA, UB92/UB04?

A HCFA is a specific medical billing form that is utilized by physician and outpatient offices to bill medical charges to insurance carriers or Third Party Claim Administrators. A UB92 or UB04 are also specific billing forms; however, they are utilized exclusively by hospitals and outpatient surgical facilities.

TIMELINESS OF FILING

All claims must be filed within 90 days from the date of accident. The quicker the claim is filed with supporting information, the faster and more accurate the claim processing will be. It is imperative to enforce this rule because not following this requirement could result in a denied claim. If the student delays this, they should understand the financial responsibility would be theirs.

IF THERE IS NO EVIDENCE OF OTHER VALID AND COLLECTIBLE INSURANCE

- A completed claim form must still be submitted
- In the event the student is not covered by any other collectible insurance through the student's or their parent's place of employment, a letter may be requested from their employer(s) verifying no other coverage exists.



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- The student can also provide a letter on company letterhead from the necessary employers verifying coverage does not exist at the time the claim is submitted.
 - If the student does not have contact with a parent, please indicate this on the claim form.
 - Students that are independent of their parents need to write a short letter indicating this information.
 - The letter must be signed/dated by the student.

HMO/PPO PLANS

If an injured student has an HMO/PPO insurance arrangement, it is highly recommended to refer them to their primary care physician or obtain authorization that will allow you to use a non-network provider whenever possible. If it is not possible to use the network and benefits are denied, a written statement of denial must be sent with the claim submission.

Disclaimer

- The foregoing summary does not take the place of or alter any of the conditions, exclusions, and other terms of the insurance policy herein summarized. It is merely a short guide to the plan design in force. The policy itself should be reviewed carefully and questions on coverage, claims and all other insurance matters should be referred to your Mercer contacts.
- Mercer does not have authority over the adjudication of a claim and Mercer does not pay claims on behalf of an insurer. Claims are subject to verification of coverage and benefits in the policy. Payment of claim by another provider does not guarantee payment by your Carrier. Full details of the coverage are contained in your Policy.