



John E. Roberts, Executive Director

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L-A/Aug 2017 Memo-Concus

TO: Superintendents of MHSAA Member Schools

FROM: Mark Uyl, Executive Director

DATE: August 2018

SUBJECT: **Insurance Benefits**

As you know, MHSAA membership is entirely free of expense to member junior high/middle schools and high schools. There are no membership dues and no MHSAA postseason tournament entry fees.

Among the no-cost-to-schools benefits of MHSAA membership is the Catastrophic Accident Medical Insurance Policy which pays up to \$500,000 for medical expenses left unpaid by other insurance after a deductible of \$25,000 per claim in paid medical expenses has been met. All students enrolled in grades 6 through 12 at MHSAA member schools who are eligible under MHSAA rules and participating in practices or competition in sports under the MHSAA's jurisdiction are covered by this policy for injuries related to their athletic participation.

Since the 2015-16 school year, the Michigan High School Athletic Association has provided athletic participants at each MHSAA member junior high/middle school and high school with additional insurance that is intended to pay accident medical expense benefits resulting from a suspected concussion. The injury must be sustained while the athlete is participating in an MHSAA covered activity. Policy limit is \$25,000 for each accident. Covered students, sports and situations follow the catastrophic accident medical insurance.

**This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 6 through 12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or under-insured. Accident medical deductibles and co-pays left unpaid by other policies are reimbursed under this program to the limits of the policy.**

Regarding the new program, you will find enclosed . . .

- A sample letter for schools to send to each student-athlete's parents or guardians
- Summary of Coverage
- Instructions on "How to File a Claim"
- Incident Report
- Other Insurance Questionnaire

MU/ky

Enclosures

Electronic Copies to Principals & Athletic Directors

August 2018

Dear Parent/Guardian,

School sports participation, like much of what our children enjoy, has some inherent risk of injury. However, the leadership of interscholastic athletics in this school district and across the state of Michigan is attempting both to provide as safe an experience as possible and enhance the health of our student-athletes.

As a part of these efforts, the Michigan High School Athletic Association provides all of its member schools with a Catastrophic Accident Medical Insurance Policy which pays up to \$500,000 for medical expenses left unpaid by other insurance after a deductible of \$25,000 per claim in paid medical expenses has been met. All students enrolled in grades 6 through 12 at MHSAA member schools who are eligible under MHSAA rules and participating in practices or competition in sports under the MHSAA's jurisdiction are covered by this policy for injuries related to their athletic participation.

Since the 2015-16 school year, the Michigan High School Athletic Association has provided eligible athletic participants at each MHSAA member junior high/middle school and high school with additional insurance that is intended to pay accident medical expense benefits resulting from a suspected concussion. The injury must be sustained while the athlete is participating in an MHSAA covered activity. Policy limit is \$25,000 for each accident. Covered students, sports and situations are identical to the catastrophic accident medical insurance which, if the \$25,000 threshold is reached, would require a separate claim to be made.

**This new program intends to assure that all eligible student-athletes in MHSAA member schools in grades 6 through 12, male and female, in all levels of all sports under the jurisdiction of the MHSAA, receive prompt and professional attention for head injury events even if the child is uninsured or under-insured. Accident medical deductibles and co-pays left unpaid by other policies are reimbursed under this program to the limits of the policy.**

Should you have need to make a claim under this new program, contact [terri.bruner@kandkinsurance.com](mailto:terri.bruner@kandkinsurance.com), or phone 800-237-2917 toll free.

Sincerely,

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# Concussion Insurance Program Guide



## Headstrong Concussion Insurance Policy Information

### Michigan High School Athletic Association

Broker: Dissinger Reed

Third Party Administrator (TPA): K&K Insurance

Insurance Carrier: Nationwide Life Insurance Company – AM Best Rated A+XV

- **Policy #:** JXS0000030047100
- **Coverage Period:** August 1, 2018 – August 1, 2019
- **Deductible:** \$0 per claim
- **Eligible Person:** All athletes participating in a Covered Activity
- **Covered Activities:** Participating in practice or play of sports governed and/or sponsored by the MHSAA
- \$25,000 per injury medical maximum
- 1-year benefit period (Benefits will be payable for 1 year from the injury date)
- Usual and Customary 100%
- Accidental Death & Dismemberment \$5,000
- Accidental Death and Dismemberment Aggregate \$250,000

The HeadStrong Concussion Insurance Program was specifically developed to insure student athletes from the high cost of concussion treatment and neurological follow up that may be required after a suspected concussion.

The student athlete has 'first dollar' coverage (zero deductible) for concussion assessment and treatment.

Coverage is secondary/excess to any other valid and collectable insurance but will become the primary payor, if no other insurance is available.

Program Highlights Include:

- \$0 deductible and no Co-pays
- Tele-med Services, when needed
- No restrictions on specific doctors
- No referrals needed for treatment
- No internal limits
- No specific procedure maximums
- Neurological follow up care When medically necessary and billed at U&C.

### How to file a claim:



[kk.newpaclaims@kandkinsurance.com](mailto:kk.newpaclaims@kandkinsurance.com)



Fax: (260) 459-5915  
Phone: (800) 237-2917



K&K Insurance/Specialty Benefits  
1712 Magnavox Way  
Ft. Wayne, IN 46804

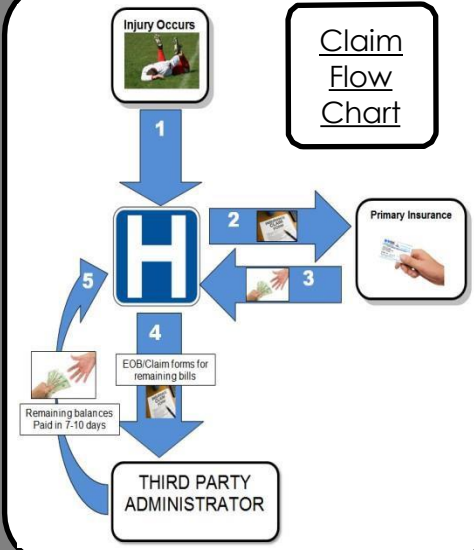
Please submit the completed and signed claim form along with itemized bills and EOB's from the primary insurance carrier. The more information you can provide upfront, the better. Claims payments are expedited with CLEAN submissions allowing us to pay you providers quickly.

### Third Party Administrator



[www.kandkinsurance.com](http://www.kandkinsurance.com)

Claim  
Flow  
Chart



### HOW TO SUBMIT A CLAIM UNDER THE CONCUSSION PROGRAM

- 1) Submit the incident report within 365 days of the injury.
- 2) Make certain that the incident report is completed in its entirety, including the policy number (JXS0000030047100), with accurate and detailed injury information and how the accident happened.
- 3) The incident report **MUST BE SIGNED** by a representative of the school. **INCIDENT REPORTS WHICH ARE NOT SIGNED, WILL DELAY THE CLAIM.**
- 4) Physician billings on CMS1500 forms and hospital/facility billings on UB04 forms would be preferred as these forms contain all the necessary coding required to process a claim. See bullets #5 & 6 for additional instruction regarding bills.
- 5) If the injured participant has primary insurance, each bill should be submitted with the primary insurance Explanation of Benefits or denial.
- 6) If the injured participant has primary insurance, all providers should be informed of the primary insurance information so they are billed first, and the K&K information for the concussion program insurance billed second.
- 7) When the injured participant does not have primary insurance, we have agreements through PPO networks that allow many bills to be reduced with contractual discounts. We encourage injured participants **NOT** to pay claims in advance of submitting them to us, so these discounts can be used.

### PRIMARY CONTACT



**Justin Vandewynkle**

8700 Indian Creek Pkwy  
Ste 320  
Overland Park, KS 66210  
913-491-6385

[jvandewynkle@dissingerreed.com](mailto:jvandewynkle@dissingerreed.com)





1712 Magnavox Way P.O. Box 2338  
 Fort Wayne, Indiana 46801  
 PH (800) 237-2917  
 Fax (312) 381-9077  
 http://www.kandkinsurance.com

# K&K INCIDENT REPORT

Michigan High School Athletic Association  
 Concussion Coverage

(PLEASE PRINT)

NATURE	<input type="checkbox"/> BODILY INJURY <input type="checkbox"/> OTHER: _____
TIME & PLACE OF INCIDENT	DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM EVENT NAME: _____ EVENT TYPE: _____ CONDUCTED BY: _____ LOCATION: _____
HAPPENED TO	NAME: _____ SSN: _____ DATE OF BIRTH: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female    PHONE: (    ) _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
FUNCTION	AS: <input type="checkbox"/> ATHLETE <input type="checkbox"/> OTHER: _____
APPARENT INJURY OR DAMAGE	BODY PART: _____ CONDITION: _____ <input type="checkbox"/> ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER: _____ <input type="checkbox"/> AMBULANCE, TAKEN TO: _____ CITY: _____ <input type="checkbox"/> FATALITY
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF THE INCIDENT? _____ _____ _____ _____
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED: _____ _____ _____ _____
OTHER SCHOOL INSURANCE	DOES THE SCHOOL PROVIDE ANY OTHER ACCIDENT MEDICAL COVERAGE FOR THE STUDENTS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY: _____ _____ _____
INSURED	NAME OF INSURED: _____ POLICY#: JXS0000030047100 MHSAA MEMBER SCHOOL NAME: _____ PHONE: (    ) _____ CITY: _____ STATE: _____
INSURED REPRESENTATIVE	<input type="checkbox"/> MHSAA Member School Administrator <input type="checkbox"/> OTHER: _____ NAME: _____ PHONE: (    ) _____ TITLE: _____ ORGANIZATION: _____ SIGNATURE: _____ DATE: _____

**COMPLETE ALL SECTIONS AND FAX OR MAIL IMMEDIATELY TO:**  
**K&K INSURANCE GROUP, INC., P.O. BOX 2338, FORT WAYNE, IN 46801-2338**  
 THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMBER, AND SIGNATURE OF THE INSURED/REPRESENTATIVE  
 BEFORE RETURNING OR PROCESSING MAY BE DELAYED



# OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: \_\_\_\_\_ INTERNATIONAL STUDENT  Yes  No  
 EMANCIPATED STUDENT:  Yes  No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT:  Yes  No  
 NAME OF INSURED: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

FATHER	MOTHER
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IS FATHER DECEASED?  Yes  No  
 IS FATHER LEGALLY RESPONSIBLE?  Yes  No  
 FATHER'S NAME (if injured is a minor) \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_  
 EMPLOYED?  Yes  No SELF-EMPLOYED?  Yes  No  
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE?  Yes  No  
 EMPLOYER NAME: \_\_\_\_\_  
 EMPLOYER ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_  
 CONTACT PERSON: \_\_\_\_\_  
 Do you have group medical insurance coverage through your employment?  
 Yes  No  
 If Yes, is it:  Individual  Family  
 If No, please be advised K&K may contact your employer to verify no primary insurance is in force.  
 INSURANCE COMPANY: \_\_\_\_\_  
 INSURANCE COMPANY ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 TYPE OF PLAN:  HEALTH MAINTENANCE ORGANIZATION (HMO)  
 PREFERRED PROVIDER ORGANIZATION (PPO)  
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE  
 OTHER (describe) \_\_\_\_\_

IS MOTHER DECEASED?  Yes  No  
 IS MOTHER LEGALLY RESPONSIBLE?  Yes  No  
 MOTHER'S NAME (if injured is a minor) \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_  
 EMPLOYED?  Yes  No SELF-EMPLOYED?  Yes  No  
 DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE?  Yes  No  
 EMPLOYER NAME: \_\_\_\_\_  
 EMPLOYER ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_  
 CONTACT PERSON: \_\_\_\_\_  
 Do you have group medical insurance coverage through your employment?  
 Yes  No  
 If Yes, is it:  Individual  Family  
 If No, please be advised K&K may contact your employer to verify no primary insurance is in force.  
 INSURANCE COMPANY: \_\_\_\_\_  
 INSURANCE COMPANY ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 POLICY NUMBER: \_\_\_\_\_  
 TYPE OF PLAN:  HEALTH MAINTENANCE ORGANIZATION (HMO)  
 PREFERRED PROVIDER ORGANIZATION (PPO)  
 STANDARD MEDICAL AND HOSPITALIZATION COVERAGE  
 OTHER (describe) \_\_\_\_\_

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: \_\_\_\_\_ PARENT/GUARDIAN/MOTHER SIGNATURE: \_\_\_\_\_  
 DATE: \_\_\_\_\_ DATE: \_\_\_\_\_

I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE K&K OR ITS REPRESENTATIVES TO FURNISH TO ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER, ANY AND ALL INFORMATION WITH RESPECT TO THE ACCIDENTAL INJURY FOR WHICH I AM CLAIMING INSURANCE BENEFITS.  
 I WAIVE ANY PROVISION OF LAW TO THE CONTRARY AND HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PERSON WHO HAS ATTENDED ME, AND MY INSURANCE CARRIER OR EMPLOYER, TO FURNISH TO K&K OR ITS REPRESENTATIVES ANY AND ALL INFORMATION WITH RESPECT TO ANY SICKNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL, OR INSURANCE RECORDS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING OTHER INSURANCE COVERAGES. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THIS AUTHORIZATION IS NECESSARY TO FACILITATE THE OBTAINING AND PROVIDING OF INFORMATION NEEDED TO QUICKLY PROCESS MY CLAIM.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Note: If injured person is a minor, signature must be of parent or legal guardian.