



Mark Uyl, Executive Director

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TO: Superintendents of MHSAA Member Schools

FROM: Mark Uyl, Executive Director

DATE: August 2019

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 \$1,000,000 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 . . .

- Frequently Asked Questions on the Program and Coverage
- Information letter that the student/parent/guardian can provide to the Provider
- Incident Report
- Other Insurance Questionnaire

MU/ky

Enclosures

Electronic Copies to Principals & Athletic Directors

Frequently Asked Questions

Headstrong is an excess accident plan. What does that mean?

1. The Insurance will pay for covered charges after the primary insurance has been exhausted.
2. Also referred to as "secondary policy" - in that it will pay secondary to any primary insurance in place.
3. The insurance will also pay for any covered charges the primary insurance will not cover (including deductibles, co-pays, any other out-of-pocket charges).

How do I submit a claim?

Full details are provided in the Program Guide. You will need to fill out and submit a claim form (incident report), and Other Insurance Questionnaire to:

K&K Insurance/Specialty Benefits

1712 Magnavox Way - Ft. Wayne, IN 46804

Fax: (312) 381-9077

Phone: (800) 237-2917

Email: kk.newpaclaims@kandkinsurance.com

I have primary insurance, what policy should I give to the provider?

It is best to give the provider BOTH: primary insurance information and the K&K information for the concussion program. The provider should then work directly with K&K to bill primary insurance first, and the Headstrong Concussion Insurance second.

On the claim form: Insured Representative. Who is a Member School Administrator?

This can be a school administrator, athletic trainer, coach or another school representative. It is best to have the school representative be a person who was present at the time of the accident.

Do I need a referral to see a concussion specialist?

There are no restrictions on specific doctors, and no referral is needed.

What is the policy deductible?

The policy deductible is \$0. The insurance offers first dollar coverage for concussion assessment and treatment. The insurance will pay for out-of-pocket costs remaining from the student's primary insurance (co-pay, deductible, treatment not covered), or will become the primary payor, if no other insurance is available.

I already paid the provider out-of-pocket, will the insurance reimburse me directly?

Yes. Please submit claim form, other insurance questionnaire, along with Bills and Explanation of Benefits to K&K Insurance. It is recommended to contact K&K Insurance prior to paying for services out of pocket.

What events are "covered events?"

Participating in practice or play of sports governed and/or sponsored by the MHSAA.



Michigan High School Athletic Association
1661 Ramblewood Drive
East Lansing, MI 48823

Dear Provider:

The athlete that you are treating today is a member of the _____ team, which is a participating member of the Michigan High School Athletic Association (MHSAA).

The MHSAA has provided the athlete with an excess accident medical plan that pays for expenses related to the care of a concussion injury. This plan will pay for covered charges after the athlete's primary insurance has been exhausted. K & K Insurance is the claims administrator for the excess plan and the following information is being supplied to you in an effort to assist the claimant in obtaining maximum benefits in a timely manner.

Please submit all charges through any other primary insurance first, and then submit itemized bills (HCFA-1500 or UB-92) and the primary Explanation of Benefits to:

K & K Insurance Group/Specialty Benefits
1712 Magnavox Way
Fort Wayne IN 46804
Fax: 312-381-9077

Should you have any questions or need any additional information, please feel free to call (800) 237-2917.

Thank You



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#: 6A-BAX-00000308661-00 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: _____