Education and Leadership for a Lifetime

2100 Freeway Boulevard, Brooklyn Center, Minnesota 55430-1735 | (763) 560-2262, FAX (763) 569-0499 | www.mshsl.org

Date: August 2019

To: Athletic/Activities Directors of MSHSL Member Schools

From: Rich Matter
Assistant Director
MSHSL

Re: HeadStrong Concussion Insurance Program provided by the MSHSL

The MSHSL is pleased to provide member schools the HeadStrong Concussion Insurance Program which is specifically developed to insure student athletes/participants from the high cost of concussion treatment and neurological follow up.

The coverage period is August 1, 2019 - August 1, 2020. All students are eligible for coverage in grades 7-12, participating in activities, practice or play of sports, at the Varsity, Junior Varsity, B-Squad and Sophomore level. Program highlights include:

- Premium is 100% paid by the MSHSL, there is no cost to member schools or student participants
- $0 deductible and no co-pays
- $25,000 per injury medical maximum
- Coverage is secondary/excess to any other valid and collectible insurance
- Coverage will become the primary payor, if no other insurance is available
- 1-year benefit period from the injury date
- Accidental Death and Dismemberment $5,000
- No restrictions on specific doctors
- No referral needed for treatment

A "SAMPLE" Word document schools can use to introduce the program to parents/guardians is available at www.mshsl.org; Resources; Concussion Resource. The following is also available on the Resources page of the website.

- Program Guide - (How to Submit a Claim)
- HeadStrong Concussion - Claim Form
- HeadStrong Concussion – Other Insurance Form

For more details regarding this new insurance program contact Rich Matter at rmatter@mshsl.org .

HeadStrong

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 MSHSL.

HeadStrong Concussion
Insurance Program

Each year it is estimated that up to 3.8 million young athletes will sustain a sports related concussion (CDC). At Dissinger Reed, we understand today's inherent risk of concussions within youth associations, leagues and teams. The importance of providing these young athletes with the most comprehensive neurological/ concussion care will ensure your students are safe to return to the field, courts, and classroom.

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

When your participating organization takes part in the HeadStrong Concussion Insurance Program™, your athletes are automatically covered with no underwriting process involved. Coverage is secondary/excess to any other valid and collectible insurance but will become the primary payor, if no other insurance is available.

The HeadStrong Concussion Insurance Program™ proudly insures over 660,000 student athletes across the country. We look forward to discussing how this exclusive program will not only ensure your young athletes are well-covered in the case of a concussion, but will also help protect the overall liability of your association, league or team.

Program Highlights Include:

- **$25,000 Accident Medical Concussion Coverage (includes neurological follow up)**
- **$0 Deductible and no Co-pays**
- **$5,000 Accidental Death & Dismemberment**
- **Telemed Services provided, when needed**
- **No restrictions on specific doctors; no referrals needed for treatment**
- **No internal limits or specific procedure maximums**
- **A+ rated carrier with Financial XV backing**
- **$1.50 per participant (3,500 minimum participants to initiate coverage**
- **Neurological follow up care – When medically necessary and billed at U&C**
- **Assists with high deductible primary insurance plans**

Excess Accident Medical Limits:
Maximum: $25,000 per injury
Usual & Customary 100%
Benefit Period: 1 Year
Deductible: $0 per claim
Accidental Death & Dismemberment $5,000
Accidental Death & Dismemberment Aggregate $250,000

Eligible Person:
All athletes participating in a Covered Activity.

Covered Activities:
Participating in practice or play of sports governed and/or sponsored by the Participating Organization.

Definition of Injury:
For the Accidental Medical Expense benefits, the following definition of Injury applies:
1. Directly and independently caused by a specific Accidental contact with another body or object;
2. A source of loss that is sustained while the Insured Person is covered under the Policy and while he or she is taking part in a Covered Activity; and
3. Resulting in a concussion.

Definition of Concussion:
A specific brain injury defined as a complex patho-physiological process affecting the brain, induced by trauma to the brain and diagnosed by a Physician practicing within the scope of his or her license.

d:r DISSINGER REED
8700 Indian Creek Parkway Suite 320
Overland Park, KS 66210 USA
(800) 886-9183
(913) 491-6385
dissingerreed.com
info@dissingerreed.com

Program Resources
Accompanying Information

The HeadStrong Concussion Insurance Program was developed by Dissinger Reed to specifically insure student athletes from the high cost of concussion treatment and neurological follow up.

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 specific procedure maximums

Contact for Claims:
kk.newpaclaims@kandkinsurance.com
Fax: (312) 381-9077
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

HeadStrong Concussion Insurance

HeadStrong Concussion Insurance Policy Information

Minnesota State High School League
Broker: Dissinger Reed

Third Party Administrator (TPA): K&K Insurance

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

Policy #: JXS0000030824700
Coverage Period: August 1, 2019 – August 1, 2020
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 MSHSL
$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
AD&D Aggregate $250,000

K&K INSURANCE

HOW TO SUBMIT A CLAIM UNDER THE CONCUSSION PROGRAM

1) Submit the incident report within 30 days of the injury, or as quickly as possible.
2) Make certain that the incident report is completed in its entirety, including the policy number (JXS0000030824700), 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 an 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.

Claims

To File a Claim:

1) **Incident Report**
   - Must be signed by school administrator
     - Ideally a person present at time of accident
   - When possible, submit prior to treatment from provider/specialist

2) **Other Insurance Questionnaire**
   - Submit along with Incident Report
   - Ensures prompt claims payment
   - Minimizes paperwork for student/family
     - Submit **even if:**
     - No existing primary insurance
     - Primary insurance denies or does not cover provider

K&K INSURANCE

K&K INCIDENT REPORT

(PLEASE PRINT)

NATURE	☐ BODILY INJURY ☐ PROPERTY DAMAGE ☐ OTHER:
TIME & PLACE OF INCIDENT	DATE: EVENT NAME: EVENT TYPE: LOCATION:
HAPPENED TO	NAME: DATE OF BIRTH: SEX: ☐ M ☐ F ADDRESS: CITY:
FUNCTION	AS: ☐ ATHLETE ☐ PARTICIPANT ☐ SPECTATOR ☐ OTHER:
APPARENT INJURY OR DAMAGE	BODY PART: CONDITION: (Laceration, Concussion, Sprain, Fracture) ☐ ON-SITE CARE ONLY, BY (EMT'S, COACH, NURSE, ETC.) ☐ AMBULANCE, TAKEN TO: ☐ FATALITY
OCCASION	WHAT WAS THE SITUATION AND EXACT LOCATION AT THE TIME OF INCIDENT?
INCIDENT DESCRIPTION	DESCRIBE WHAT HAPPENED:
WITNESSES (if known)	NAME: ADDRESS: PHONE: ( )
INSURED	NAME OF INSURED: CLUB NAME: CITY:
INSURED REPRESENTATIVE	☐ COACH ☐ OFFICIAL ☐ TRAINER ☐ PROVIDER NAME: TITLE: SIGNATURE

COMPLETE ALL SECTIONS AND F
K&K INSURANCE GROUP, INC., P.O. BO
THIS FORM MUST INCLUDE THE INSURED NAME, POLICY NUMB
BEFORE RETURNING OR PROCE

K&K

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT? ☐ Yes ☐ No
EMANCIPATED STUDENT? ☐ Yes ☐ No COVERAGE DESIRED FOR OTHER PAYMENT: ☐ Yes ☐ No
NAME OF INSURED: _____ POLICY NO:

FATHER	MOTHER
IS FATHER DECEASED? ☐ Yes ☐ No	IS MOTHER DECEASED? ☐ Yes ☐ No
IS FATHER LEGALLY RESPONSIBLE? ☐ Yes ☐ No	IS MOTHER LEGALLY RESPONSIBLE? ☐ Yes ☐ No
FATHER'S NAME (if deceased, write DECEASED)	MOTHER'S NAME (if deceased, write DECEASED)
SOCIAL SECURITY #:	SOCIAL SECURITY #:
EMPLOYED? ☐ Yes ☐ No SELF-EMPLOYED? ☐ Yes ☐ No	EMPLOYED? ☐ Yes ☐ No SELF-EMPLOYED? ☐ Yes ☐ No
DISABLED OR RECEIVED OTHER PUBLIC ASSISTANCE? ☐ Yes ☐ No	DISABLED OR RECEIVED OTHER PUBLIC ASSISTANCE? ☐ Yes ☐ No
EMPLOYER NAME:	EMPLOYER NAME:
EMPLOYER ADDRESS:	EMPLOYER ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE: ( )	PHONE: ( )
CONTACT PERSON:	CONTACT PERSON:
Do you have group medical insurance coverage through your employer? ☐ Yes ☐ No	Do you have group medical insurance coverage through your employer? ☐ Yes ☐ No
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY:	INSURANCE COMPANY:
INSURANCE COMPANY ADDRESS:	INSURANCE COMPANY ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
POLICY HOLDER:	POLICY HOLDER:
TYPE OF PLAN: ☐ HEALTH MAINTENANCE ORGANIZATION (HMO) ☐ PREFERRED PROVIDER ORGANIZATION (PPO) ☐ STANDARD MEDICAL AND HOSPITALIZATION COVERAGE ☐ OTHER (describe)	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.

PRINT NAME OF INSURED OR PARENT/GUARDIAN: _____ PRINT NAME OF AUTHORIZED REPRESENTATIVE: _____
DATE: _____ NAME: _____

1038 7/11

Minnesota State High School League
2100 Freeway Blvd
Brooklyn Center, MN 55430

Dear Provider:

The athlete that you are treating today is a member of the _____ team, which is a participating member of the Minnesota State High School League (MSHSL).

The MSHSL 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

Minnesota State High School League
Concussion Coverage

(PLEASE PRINT)

NATURE
❑ BODILY INJURY ❑ OTHER:_____

TIME & PLACE OF INCIDENT
DATE:_____ TIME:_____ ❑ AM ❑ PM
EVENT NAME:_____
EVENT TYPE:_____ CONDUCTED BY:_____
LOCATION:_____

HAPPENED TO
NAME:_____ SSN:_____
DATE OF BIRTH: _____ SEX: ❑ Male ❑ Female PHONE: (_____)_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

FUNCTION
AS: ❑ ATHLETE
❑ OTHER:_____

APPARENT INJURY OR DAMAGE
BODY PART:_____
CONDITION:_____
❑ ON-SITE CARE ONLY, BY (PHYSICIAN) (EMT) (TRAINER) OTHER:_____
❑ AMBULANCE, TAKEN TO:_____ CITY:_____
❑ 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? ❑ Yes ❑ No
IF YES, PLEASE PROVIDE THE NAME OF THE COMPANY:_____

INSURED
NAME OF INSURED:_____ POLICY#: 6A-BAX-30856200
MSHSL MEMBER SCHOOL NAME:_____ PHONE: (_____)_____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
❑ MSHSL Member School Administrator ❑ 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

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)_____

MOTHER

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)_____

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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.