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, or phone 800-237-2917 toll free.

Sincerely,

_____

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

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

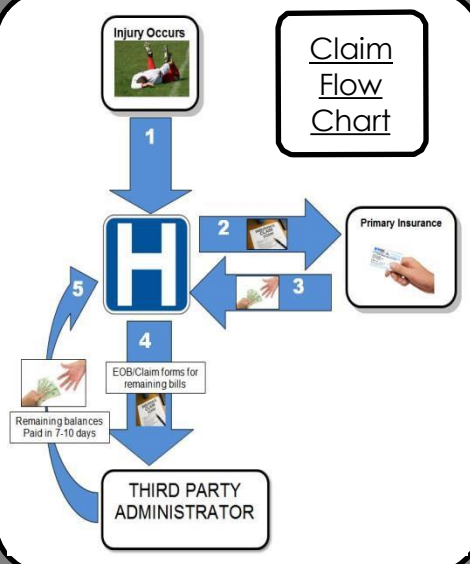
K&K Insurance/Specialty Benefits
1712 Magnavox Way
Ft. Wayne, IN 46804

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

K&K INSURANCE

www.kandkinsurance.com



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
d:r DISSINGER REED
8700 Indian Creek Pkwy
Ste 320
Overland Park, KS 66210
913-491-6385
jvandewynkle@dissingerreed.com

HeadStrong Concussion Insurance

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
❑ 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#: JXS0000030047100
MHSAA MEMBER SCHOOL NAME:_____ PHONE: (_____)_____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
❑ MHSAA 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)_____

SOCIAL SECURITY #: _____

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 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) _____

SOCIAL SECURITY #: _____

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 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:_____