Concussion Insurance Program Guide

IOWA HIGH SCHOOL ATHLETIC ASSOCIATION

The HeadStrong Concussion Insurance Program was specifically developed to 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 internal limits
- No specific procedure maximums
- Neurological follow up care When medically necessary and billed at U&C.

HeadStrong Concussion Insurance Policy Information

Iowa 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 #**: JXS0000030094200
- **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 IHSAA
- $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

Contact for Claims:

kk.newpaclaims@kandkinsurance.com
Fax: (312) 381-9077
Phone: (800) 237-2917

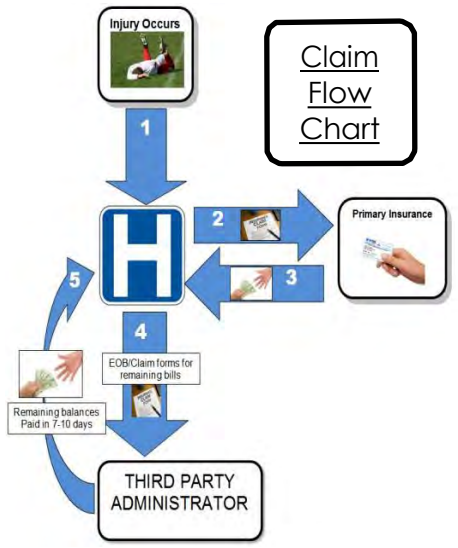
K&K Insurance/Specialty Benefits
1712 Magnavox Way
Ft. Wayne, IN 46804

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 allowing us to pay your 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 (JXS0000030094200), 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 below 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

d:r DISSINGER REED

Justin Vandewynkle
8700 Indian Creek Pkwy
Ste 320
Overland Park, KS 66210
Phone:(913) 491-6385
jvandewynkle@dissingerreed.com

HeadStrong Concussion Insurance

HeadStrong Concussion Insurance: 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?

More 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 Iowa High School Athletic Association (IHSAA).

Iowa High School Athletic Association
1605 South Story Street
Boone, IA 50036

Dear Provider:

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

The IHSAA 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: 260-459-5915

Should you have any questions or need any additional information, please feel free to call K & K Insurance Group/Specialty Benefits claims department at: (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

Iowa 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#:_____
IHSAA MEMBER SCHOOL NAME:_____ PHONE: (_____)_____
CITY:_____ STATE:_____

INSURED REPRESENTATIVE
❑ IHSAA 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:
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- ❍ 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:_____

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1605 South Story Street
Boone, IA 50036

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Thank You