michigan high school athletic association

Mark Uyl, Executive Director

1661 Ramblewood Drive • East Lansing, MI 48823-7392 • 517-332-5046 • Fax 517-332-4071 • Web mhsaa.com

L-A/Aug 2022 Memo-Concus

TO: Superintendents of MHSAA Member Schools

FROM: Mark Uyl, Executive Director

DATE: August 2022

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

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Enclosures

Electronic Copies to Principals & Athletic Directors

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:
Cheryl Walsh - cheryl.walsh@mutualofomaha.com
(402)-351-5325
Fax: (402) 351-4732
Phone: (800) 524-2324
Mutual of Omaha:
3300 Mutual of Omaha Plaza
Omaha, NE 68175
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 Policy Information

High School Association: Michigan High School Athletic Association

Broker: Dissinger Reed

Claims Payor: Mutual of Omaha

Insurance Carrier: Mutual of Omaha Company – AM Best Rated A+XV

Policy #: SR2014MI-P-054180-008
Coverage Period: August 1, 2021 – August 1, 2022
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 AD&D Aggregate $250,000

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 (SR2014MI-P-054180-008), 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 Mutual of Omaha 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.

DISSINGER REED

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:

Mutual of Omaha
3300 Mutual of Omaha Plaza Omaha, NE 68175
Phone: 1-800-524-2324
Fax: 402-351-4732
Email: specialrisk.claims@mutualofomaha.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 Mutual of Omaha information for the concussion program. The provider should then work directly with Mutual of Omaha 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 Mutual of Omaha. It is recommended to contact Mutual of Omaha 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 State High School Association

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. Mutual of Omaha 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:

Mutual of Omaha
3300 Mutual of Omaha Plaza
Omaha, NE 68175
Fax: 402-351-4732

Should you have any questions or need any additional information, please feel free to call (800) 524-2324

Thank You

Claim Form - HeadStrong Concussion Insurance

Complete and return this form to:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries (800) 524-2324

Section I Organization/School and Claimant Information (required)

TO BE COMPLETED BY ORGANIZATION OR AUTHORIZED OFFICIAL

Policy Effective Date _____

Policy Expiration Date _____

Policy Number 054180-008

Claim being filed is a:

☐ Noncatastrophic claim

☐ Catastrophic claim

Policyholder Name Michigan High School Athletic Association

Policyholder Address _____
(Street) (City) (State) (ZIP Code)

Policyholder Phone Number _____

Injured Party (Claimant) Information

Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Claimant is a: ☐ Player ☐ Coach ☐ Official ☐ Other _____

Verify that accident occurred during an activity sponsored or sanctioned by the policyholder, and whether claimant was a member at the time of the accident.

☐ Yes – Sponsored/Sanctioned activity

☐ Yes – Claimant was active member on date of accident

Under whose supervision? _____

Was he/she a witness? ☐ Yes ☐ No

Name of team/sport _____

Date of accident _____ Time of accident _____ ☐ a.m. ☐ p.m.

Location of accident _____

Type of activity _____

Accident occurred during: ☐ Game ☐ Practice ☐ Tournament ☐ Camp/Clinic ☐ Interscholastic/Intercollegiate Sport ☐ Intramural Sport ☐ Other _____

I certify that the above information is true and correct.

Authorized Signature _____

Title _____ Date _____

Section II Additional Claim Details (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

Claimant Name _____

Describe accident _____

Body part injured _____

First treatment date _____

Dates claimed _____

Type of benefits claimed: ☐ Accident-Medical ☐ Dental ☐ Sickness-Medical ☐ Loss of Time

Name of family physician _____

Address _____

Phone Number _____

Has treatment been completed? ☐ Yes ☐ No

Section III Statement of Other Insurance (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

Father/Guardian Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Employer _____

Employer Phone Number _____ ☐ Self-Employed ☐ Unemployed

Mother/Guardian Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Employer _____

Employer Phone Number _____ ☐ Self-Employed ☐ Unemployed

Is Claimant covered under any other medical and/or dental insurance policy? ☐ Yes ☐ No

Is Claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐ Yes ☐ No

Important Notice: This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with an itemized bill and this completed form.

Payment will be made to the providers of service (Hospital, Physician or others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

Details of Other Insurance Coverage (required)
COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

Insured Name _____ I.D. Number _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Insured Group Number/Name _____

Company Name _____

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

**Please include copy of insurance card (both sides)

Note: If your son or daughter has medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree, please give name, address and phone number of responsible party:

Responsible Party Name _____
(First) (Last)

Address _____
(Street) (City) (State) (ZIP Code)

Phone Number _____

Section IV Statement of Certification (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

I hereby certify that all preceding information is true and complete, and I have reviewed the fraud statement for my state.

New York Claimants: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. (PURSUANT TO 11 NYC RR86)

Signature of Parent/
Guardian/Claimant (required) _____ Date _____

Section V Authorization to Release Information (required)

COMPLETED BY CLAIMANT, PARENT OR GUARDIAN

I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by Mutual of Omaha Insurance Company or its representatives, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Parent/
Guardian/Claimant (required) _____ Date _____

Claim Serial Number (for office use only)

Guarantee Trust Life Ins. Co.
administered by
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

ACCIDENT CLAIM FORM

PARENT/GUARDIAN TO COMPLETE
ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name _____ Exact Date of Accident _____

Student's Date of Birth _____

FATHER

Father's Full Name _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____
Employer Name _____
Employer Address _____
City _____ State _____ Zip _____

Self Employed? ☐ YES ☐ NO

PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:

Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan _____
Phone Number _____
Group Number _____

If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

MOTHER

Mother's Full Name _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____
Employer Name _____
Employer Address _____
City _____ State _____ Zip _____

Self Employed? ☐ YES ☐ NO

PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:

Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan _____
Phone Number _____
Group Number _____

If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

AUTHORIZATION - To Permit Use and Disclosure of Health Information

First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

_____
Name of Authorized Representative, or Next of Kin

_____
Name of Claimant

_____ _____
Signature of Authorized Representative or Next of Kin Date

_____ _____
Signature of Claimant (If claimant is 18 or older) Date

_____
Relationship of Authorized Representative or Next of Kin to Claimant

Michigan High School Athletic Association - SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends Michigan High School Athletic Association in _____ School District

Student's Full Name (Last, First, MI): _____ Sex: ☐ Male ☐ Female Grade: _____

Student's Home Address: _____

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM

Detailed Description of Accident: How did it occur? (or attach accident report completed by the school representative who witnessed the accident) _____

Where did it occur? _____

Part of body injured: _____ ☐ Right ☐ Left

Activity: _____ ☐ Interscholastic ☐ Intramural ☐ Club ☐ Other (describe) _____

Name of school authority supervising activity: _____

Was supervisor a witness to the accident? ☐ Yes ☐ No If No, date reported to school: _____

Signature of School Official: _____ Date: _____ Title of School Official: _____

First Agency
5071 West H Avenue
Kalamazoo, MI 49009

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information to process a claim for benefits.

Policy/Certificate # 214-156-458

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to First Agency, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent First Agency has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that First Agency may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of First Agency to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to First Agency pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

(Print Please) Name of Patient — Date of Birth

Signature of Patient — Date

(Please Print) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin — Date

Dear Participant:

The MHSAA provides accident insurance coverage for all participants in regularly scheduled, sponsored, supervised and approved practice sessions or contests/games by the MHSAA. Outlined below is important information regarding this coverage. It is intended as a brief description for reference only, and is not the policy.

Only ***ACCIDENTS*** that occur in MHSAA sponsored and supervised sports activities are covered.

DEFINITION OF ACCIDENT:

An unexpected, sudden and definable event which is the direct cause of a bodily injury, independent of any illness, prior injury or congenital predisposition.

Conditions that result from participating in an activity do not necessarily constitute accidents. For example, illnesses, diseases, degeneration, conditions caused by continued stress to a particular area of the body, and existing conditions aggravated by an accident are not covered.

A. This plan of insurance is ***EXCESS ONLY***. It will not duplicate benefits paid or payable by any other insurance or plan including HMO's or PPO's.

B. The policy will not cover expenses payable under the insured's HMO (Health Maintenance Organization), or PPO (Preferred Provider Organization). If the insured chooses not to use an authorized medical vendor (under HMO or PPO), the policy will only cover expenses incurred that it would have honored had the insured used the proper medical vendor.

C. Medical treatment for a covered accident must begin within 26 weeks of that accident. Only expenses incurred within 10 years from the date of accident are considered. Benefits are determined on the basis of ***REASONABLE AND CUSTOMARY*** for the geographic location where services are performed.

D. A $25,000 deductible, which may be satisfied by other valid collectible insurance or plan payments, will be applied to each claim. The deductible incurral period is 24 months from the date of accident.

E. Specific exclusions of the policy include, but are not limited to, sickness, disease, or hernia in any form; non-prescription drugs; fighting; and orthotics not prescribed exclusively for rehabilitation (e.g., playing brace, mouth guard).

E. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

Accidents must be reported to the program official within 20 days. Medical bills must be submitted to First Agency, Inc. within 90 days after date of treatment. Questions regarding claim procedures may be directed to First Agency at 5071 West H Avenue, Kalamazoo, Michigan 49009 or 269/381-6630 or Fax 269/381-3055.

HOW TO FILE YOUR ***ACCIDENT*** CLAIM FORM:

1. Complete ***ALL*** blanks. If information is not applicable, indicate the ***reason*** it is not (e.g., deceased, unknown).

2. Attach all ***ITEMIZED*** bills to date (***not*** balance due statements) for ***MEDICAL EXPENSES ONLY***. Subsequent medical bills can be submitted within 90 days after date of treatment.

3. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge ***must*** be processed by all other insurances/plans before they can be processed by First Agency, Inc.)

4. If you are employed and no coverage is provided by your employer, ***A LETTER OF VERIFICATION FROM YOUR EMPLOYER STATING THAT NO COVERAGE IS PROVIDED MUST BE SUBMITTED.***

5. **Mail claim form within 90 days of the accident to:**

Guarantee Trust Life Ins. Co. administered by
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

Michigan High School Athletic Association/MI