



6210 E Highway 290
Austin, Texas 78723-1098
(512) 224-3800
1-800-859-5995

P.O. Box 12058
Austin, Texas 78711-2058
(512) 224-3800
1-800-859-5995

June 18, 2015

HOLLON OIL COMPANY
PO BOX 8068
WESLACO, TX 78599-8068

Re: Workers' Compensation Coverage
TSF-0001133067 20150701 - Policy # 0001133067

Thank you for placing your account with Texas Mutual Insurance Company. For your convenience, we are enclosing a copy of your workers' compensation policy along with two claim-reporting forms you may use if one of your employees has a work-related accident.

You can also save time by reporting your injuries online at texasmutual.com. Our website also offers services that allow you to view your claim information, create your own customized loss reports, manage your workplace safety programs and stay up-to-date with *Texas Mutual*® news and events.

As the state's leading provider of workers' compensation insurance, we strive to set the standard in Texas for service, communication, and ease of doing business. If you have any questions, please email us at information@texasmutual.com or call us at 1-800-859-5995.

Underwriting Department



Thank you for choosing Texas Mutual Insurance Company. We created this brief guide to help you get the most out of your *Texas Mutual*® coverage.

Understand your premium

We estimate your annual premium at the beginning of your policy by reviewing your payroll, the type of work your employees perform, your loss history, your safety programs and other factors. You must pay the full amount at the beginning of your policy year, unless you arrange for premium financing or your account qualifies for interim payroll reporting.

At the end of your policy period, we will review your account for changes in your payroll or operations during the policy year. We will then adjust your premium, if necessary. You may get money back, or you may be billed accordingly.

Report injuries

- Report injuries the same day they happen, if possible. The fastest way to report injuries is at www.texasmutual.com. If you cannot report online, you may report by phone at (800) 859-5995, or send a completed DWC-1 form by fax to (877) 404-7999 or by mail to Texas Mutual Insurance Company, P.O. Box 12029, Austin, Texas 78711-2029.
- Give the employee a copy of the injury report and the "Employee's Rights and Responsibilities" form.
- Keep accurate records of the dates when you take any claim-related action, including when you file a supplemental report (DWC-6 form) or wage statement (DWC-3 form). To file a DWC-3 form online, go to www.texasmutual.com, log into the Employer claim detail tool, look up the claim, and click Complete Online DWC-3 Form.
- If you have a network policy, give the employee a copy of the "Notice of Network Requirements." Have him or her sign the acknowledgment form, and keep the form for your records. The notice and acknowledgment form are available in the Health Care Network section at www.texasmutual.com.

Prevent workplace accidents

A solid workplace safety program contributes to improved productivity and lower workers' compensation costs. Visit the free safety resource center at www.texasmutual.com to learn how to prevent accidents.

[over...]

**Launch a
return-to-work
process**

When an employee misses work due to on-the-job injuries, their employer must find a way to make up for lost production. Meanwhile, the injured employee must contend with the depression and financial stress that often come with being away from work. Texas Mutual will work with you to get your injured employees well and back on the job. Visit www.texasmutual.com/safety/rtwtools.shtml for more information and free tools.

Fight fraud

Workers' compensation fraud touches everyone in the form of higher premiums. Texas Mutual employs three teams of full-time fraud investigators. They need your help to stamp out fraud. Visit the Fighting Fraud section at www.texasmutual.com to learn your role.

**Save time with
Texas Mutual®
online**

You can handle most of your workers' comp needs at www.texasmutual.com. Visit our website to report injuries, get safety training materials, review claim detail reports, submit interim payroll reports and report suspected fraud.

**Get telephone
assistance**

Use our enhanced automated phone services at (800) 859-5995 between 6:00 a.m. and 9:00 p.m. CST to:

- Verify quote and policy status, including issue date and policy period
- Check payment status, including amount and receipt date
- Retrieve return payment information, including check number and issue date
- Confirm deposit and/or annual premium amount due
- Verify claim number and assigned workers' compensation specialist
- Get address and fax information

Representatives are available between 8:00 a.m. and 5:30 p.m. CST to help with:

- Interim and final audit information
- Information and enrollment for free policyholder workshops
- Access to password-protected online services and password reset
- Workers' comp health care network information
- Any of your workers' comp needs

"Texas Mutual" is a registered service mark of
Texas Mutual Insurance Company.
Visit our website at www.texasmutual.com.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] Hollen Oil Company has workers' compensation insurance coverage from [name of commercial insurance company]

Texas Mutual Insurance Company. In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] July 1. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] Texas Mutual Insurance Company. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.



NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-EZE-OIEC (1-866-393-6432). More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation. Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

28 TAC §276.5. Employer Notification of Ombudsman Program to Employees (Effective 9/1/13)

- (a) All employers participating in the workers' compensation system shall post notice of the Office of Injured Employee Counsell's (OIEC) Ombudsman Program. This notice shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where each employee is likely to see the notice on a regular basis.
- (b) This notice of the Ombudsman Program shall be publicly posted in English, Spanish, and any other language that is common to the employer's employees.
- (c) This notice shall be the text provided by OIEC without any additional words or changes and may be obtained by:
- (1) Downloading the form on OIEC's website at: www.oiec.texas.gov; or
 - (2) Requesting the notice by calling OIEC's toll-free telephone number at: 1-866-EZE-OIEC (1-866-393-6432).

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.

| |
|---------------|
| CLAIM # _____ |
|---------------|

| |
|-------------------------|
| CARRIER'S CLAIM # _____ |
|-------------------------|

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

| | | | | | | | | | |
|--|--|---|--|----------------------------|-----------------------|---|---------------------------|---|--|
| 1. Name (Last, First, M.I.) | | 2. Sex F <input type="checkbox"/> M <input type="checkbox"/> | | 15. Date of Injury (m-d-y) | | 16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/> | | 17. Date Lost Time Began (m-d-y) | |
| 3. Social Security Number | | 4. Home Phone () | | 5. Date of Birth (m-d-y) | | 18. Nature of Injury* | | 19. Part of Body Injured or Exposed* | |
| 6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> | | | 8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> | | | 21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22. Worksite Location of Injury (stairs, dock, etc.)* | |
| 9. Mailing Address Street or P.O. Box City State Zip Code County | | | | | | | | | |
| 10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> | | | | | | | | | |
| 11. Number of Dependent Children | | | | | 12. Spouse's Name | | | | |
| 13. Doctor's Name | | | | | | | | | |
| 14. Doctor's Mailing Address (Street or P.O.Box) City State Zip Code | | | | | | | | | |
| 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box | | County City State Zip Code | | | | | | | |
| 24. Cause of Injury (fall, tool, machine, etc.)* | | | | | | | | | |
| 25. List Witnesses | | | | | | | | | |
| 26. Return to work date/or expected (m-d-y) | | | 27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 28. Supervisor's Name | | 29. Date Reported (m-d-y) | | |

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 30. Date of Hire (m-d-y) | | 31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 32. Length of Service in Current Position Months _____ Years _____ | | 33. Length of Service in Occupation Months _____ Years _____ | |
| 34. Employee Payroll Classification Code | | | | 35. Occupation of Injured Worker | | | |
| 36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly | | 37. Full Work Week is: _____ Hours _____ Days | | 38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days | | 39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/> | |

| | | | | | | | |
|---|--|--|--|--|--|------------------------------------|--|
| 40. Name and Title of Person Completing Form | | | | 41. Name of Business | | | |
| 42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone () | | | | 43. Business Location (If different from mailing address) Number and Street | | | |
| City State Zip Code | | City State Zip Code | | City State Zip Code | | City State Zip Code | |
| 44. Federal Tax Identification Number | | 45. Primary North American Industry Classification System Code (6 digit) | | 46. Specific NAICS Code (6 digit) | | 47. Texas Comptroller Taxpayer No. | |
| 48. Workers' Compensation Insurance Company | | | | 49. Policy Number | | | |

50. Did you request accident prevention services in past 12 months?
YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____





| | |
|-----------|-------|
| CLAIM # | _____ |
| Carrier # | _____ |

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

| | |
|---|---------------------|
| 1. Employer business name | 2. Employer phone # |
| 3. Employer mailing address | |
| 4. Insurance carrier name | |
| 5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____ | |
| 6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/> | |
| 7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/> | |
| 8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/> | |
| 9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/> | |

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

| | |
|------------------------------|---|
| 10. <input type="checkbox"/> | a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days. |
| <input type="checkbox"/> | b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days. |
| <input type="checkbox"/> | c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days. |
| <input type="checkbox"/> | d. The injured worker resigned or was terminated from employment: File within 10 days. |

Part III INJURED WORKER INFORMATION

| | | |
|--|---------|---|
| 11. Injured worker name | 12. SSN | 13. DOI |
| 14. Injured worker mailing address and phone # | | |
| 15. First day of lost time or reduced wages for this injury (mm/dd/yyyy) | | 16. First day of additional lost time or reduced wages (mm/dd/yyyy) |
| 17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8 th day (mm/dd/yyyy) _____ | | |
| 18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay | | 19. Has the injured worker resigned, been terminated or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____ 19a. Reason for resignation/termination _____ 19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/> |
| 20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week | | 21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____ |
| Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury | | Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same a pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage |

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker (If no longer working for the employer where injury occurred.)

Signature and Title of person completing this form _____

Date _____



***Texas Star Network®
Texas Health Care
Provider Network***

Employee Information Materials

To All Employees:

Your employer is committed to your health and safety at the workplace. Our first concern is to keep injuries from happening. If you are injured, we want to help you get better and return to work as soon as it is medically safe.

Your employer has chosen the Texas Star Network® as its workers' compensation health care network. It is a network built around occupational health care providers.

We will provide services through our network of medical providers and facilities. The Texas Star Network® specializes in treating injured workers and helping them return to work.

The network includes occupational health clinics and doctors who will provide you with medical treatment. Your doctor will also manage your return to work with your employer.

Under the program, you will receive:

- a primary treating doctor;
- other occupational health services and specialists;
- emergency health care services; and
- medical care if you are working or traveling outside of the geographic services area.

The Texas Star Network® has been built to provide you with timely and quality medical care. It is easy to access. It is here to provide you with quality medical care and assist you in returning to health and a productive life.

The enclosed materials will give you information to help you through your work related injury or illness.

Information, Instructions and your Rights and Obligations

Dear Employee:

Your employer has chosen the Texas Star Network® to manage the health care and treatment you may receive if you are injured. The Texas Star Network® is a certified workers compensation health care network. The State of Texas has approved this network to provide care for work related injuries. This program includes a network of health care providers who are trained in treating work related injuries. They are also trained in getting people back to work safely. The Texas Star Network® service area includes greater Dallas, greater Houston, Austin/San Antonio, Amarillo, Central Texas, North East Texas, El Paso, Lubbock, Midland, Rio Grande Valley, Texarkana, Nacogdoches, Central East Texas, Abilene, Victoria, Corpus Christi, Orange, Laredo, and Wichita Falls areas. These areas are shown on the enclosed map.

If you are injured at work, tell your supervisor or employer as soon as you can. The enclosed information will help you to seek care for your injury. Also, your employer will help with any questions about how to get treatment through the Texas Star Network®. You may also contact your workers' compensation insurer for any questions about your care and treatment for a work related injury. The Texas Star Network® and your employer have formed a team to provide timely health care for injured workers. The goal is to return you to work as soon as it is safe to do so.

Your Rights and Obligations...

Choosing a Treating Doctor

If you are hurt at work and you live in the network service area, you must choose a treating doctor from the Texas Star Network®. This is required for you to receive coverage of the costs for the care of your work related injury. If at the time you are injured you belong to a health maintenance organization (HMO), you may choose your HMO primary care physician as your treating doctor. You must have chosen the doctor as your primary care doctor prior to your injury. We will approve the choice of your HMO doctor if he or she agrees to the terms of the network contract. The doctor must also agree to abide by applicable laws.

If you were injured on the job prior to September 1, 2005 and the carrier determines your injury is subject to the network, you will be advised to select a Treating Doctor from the list of participating providers in the Certified HCN. All injured workers subject to the network must live in a Certified HCN service area and must be notified, in writing, by the employer/carrier of the certified HCN requirements. You may also request a doctor you chose as your HMO primary care doctor before you were hurt. You must do this upon receipt of this notice.

If your treating doctor leaves the network we will tell you in writing. You will have the right to choose another treating doctor from the list of network doctors. If your doctor leaves the network and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra 90 days.

If you believe you live outside of the service area, you may request a service area review by calling your insurer. You should provide proof to support your belief. Within 7 days of receiving your request for review, the insurer will tell you its decision. If you do not agree with the final decision of the insurer you have the right to file a complaint with the Texas Department of Insurance. Your complaint must include your name, address, telephone number, a copy of the insurer's decision and any proof you sent to the insurer for review. A complaint form is available on the department's web site at www.tdi.texas.gov. You may also ask for a form by writing to the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

When waiting for the insurer to make a decision or the Texas Department of Insurance to review your complaint, you may choose to receive all health care from the network. You may be required to pay for health care services received out of the network if it is finally decided that you do live in the network's service area.

For a list of network providers available in your area, please visit: <http://www.texasmutual.com/hcn/provdir.shtm>. The Texas Star Network online provider directory is typically updated several times a month, but no less than once a quarter.

Changing Doctors

It may happen that you become dissatisfied with your first choice of a treating doctor. You can select an alternate treating doctor from the list of network treating doctors in the service area where you live. We will not deny a choice of an alternate treating doctor. Before you can change treating doctors a second time, you must get permission from us.

Referrals

You do not have to get a referral if you have an emergency health condition. All health care services that you request will be made available by the network on a timely basis, as required by your medical condition. This includes referrals. All health care services, including referrals, will be made available no more than 21 days after you make a request.

Out-of-Network Approvals

Coventry's Network Administration Department must approve your treating doctor's out-of-network referrals (1305.006(3)) and all non-emergency, non-network providers (1305.451 (6)) before you visit those providers. If you need to request approval on a claim, please call Coventry's Network Administration Department at (888) 252-5075.

Payment for Health Care

Network doctors have agreed to look to the insurer for payment for your health care. They will not look to you for payment. If you obtain health care from a doctor who is not in the network without prior approval from the Texas Star Network®, you may have to pay for the cost of that care. You may only access non-network health care providers and still be eligible for coverage of your medical costs if one of the following situations occurs.

- Emergency care is needed. You should go to the nearest hospital or emergency care facility.
- You do not live within the service area of the network.
- Your treating doctor refers you to an out of network provider or facility. This referral must be approved by the Texas Star Network®.
- You have chosen your HMO primary care doctor. Your doctor must agree to abide by the network contract and applicable laws.

Complaints

You have the right to file a complaint with the Texas Star Network®. You may do this if you are dissatisfied with any aspect of network operations. This includes a complaint about your network doctor. It may also be a general complaint about the Texas Star Network®. Please read the enclosed Texas Star Network® Complaint Procedures, or call the Texas Star Network® Complaint Line at (800) 262-6122, to have your questions answered.

Texas Star Network®
Attention: Grievance Coordinator
3200 Highland Avenue
Downers Grove, IL 60515
Grievance Coordinator – Fax Line (630) 737-2077; ComplaintsandGrievances@cvty.com

Texas law does not permit the Texas Star Network® to retaliate against you if you file a complaint against the network. We also can not retaliate if you appeal the decision of the network. The law also does not permit us to retaliate against your treating doctor if he or she files a complaint against the network or appeals the decision of the network on your behalf. You also have the right file a complaint with the Texas Department of Insurance. The Texas Department of Insurance complaint form is available on the department's web site at www.tdi.texas.gov or you may request a form by writing to the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

What to do if you are injured while on the job...

If you are injured while on the job tell your employer as soon as possible. A list of network doctors in your service area is posted at your worksite. A complete list of doctors is also available. You will be given more instructions on how to get treatment through the Texas Star Network®. Or, you may contact us directly at the following address and/or toll-free telephone number:

**Texas Star Network®
3611 Queen Palm Dr. Ste. 200
ATTN: Client Services
Tampa, Florida 33619
(800) 381-8067**

We will help you get an appointment with a network doctor.

In case of an emergency...

If you are injured and it is an emergency, you should seek treatment at the nearest emergency facility as soon as possible. This also applies if you are injured outside the service area. It also applies if you are injured after normal business hours.

After you receive emergency care, you may need ongoing care. You will need to select a network doctor from the list that your employer has given you. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined by Texas law as a medical condition that comes up suddenly. There are acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

Non-emergency care...

Report your injury to your employer as soon as you can. Select a network treating doctor from the list given to you by your employer. Go to that doctor to be treated.

Treatment prescribed by your doctor may need to be approved in advance. You or your doctor are required to request approval from the insurer or the network for a specific treatment or services before the treatment or service is provided. You may continue to need treatment after the approved treatment is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

Texas Star Network® Preauthorization List

This list is not intended to be comprehensive or all-inclusive; because health care is an ever-evolving science, procedures and treatments requiring prior approval will also evolve. Participating Treating Providers should therefore verify specific preauthorization requirements by referring to the updated list posted at www.texasmutual.com.

Hospital/ASC

All non-emergency hospital or ASC (inpatient, outpatient, and observation) admissions including principle scheduled procedures and length of stay. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.

Surgery/Procedures/Integral Devices

All non-emergency surgeries represented by AMA CPT codes 10010-69990 and/or G codes which represent a surgical procedure performed in a setting or place of service other than the doctor's office [POS 11]). Preauthorization request should include specified hardware, implantables, external delivery system, etc. to be utilized.

- All Botox Injections
- All spinal Injections (including but not limited to):
 - Epidural Steroid Injection
 - RFTC or Cryotherapy/Cryoablation
 - Sacral Iliac Joint Injection
 - Facet Injection
 - Medical Branch Block
- Trigger Point Injections (represented by AMA CPT 20553)
- Bone growth stimulators
- Discograms
- Implantable drug delivery system
- Investigational or experimental procedures or devices as determined by ODG or listed as an AMA Category III Code.
- Stimulator Devices (including, but not limited to):
 - *TENS units
 - *Interferential units
 - *Neuromuscular stimulators
 - *Dual units
 - *Spinal Cord Stimulator
 - *Peripheral nerve Stimulator
 - *Brain Stimulator

Physical Medicine

- All Chiropractic Treatments
- Manipulations under Anesthesia (MUA)
- All Physical Therapy/Occupational Therapy (unless requestor or rendering provider/facility is participating through Align)
- Biofeedback

Diagnostics

- All initial and Repeat MRI and CT scans
- Bone density scans
- Unless otherwise specified in this list, all repeat individual diagnostic studies (series) having a billed amount greater than \$350.
- Surface Electromyography (EMG)

Other

- Durable medical equipment (DME), Prosthetics and/or Orthotics, greater than \$500.00 billed (purchase or accumulated rental or combination of rental/purchase)
- Gym memberships
- Texas Department of Insurance, Division of Workers' Compensation (DWC) Pharmacy Closed Formulary per 28 TAC §134, Subchapter F.

Alternative Treatment (including, but not limited to):

- Acupuncture Outside ODG
- Acupressure
- Yoga

Rehab Programs (including, but not limited to):

- Work Conditioning
- Work Hardening
- Chronic Pain Management Program
- Medical Rehabilitation
- Brain and Spinal Cord Rehabilitation
- Chemical Dependency Programs
- Weight loss programs

Nursing Home (including, but not limited to):

- Skilled nursing facility, including skilled care within the same facility
- Convalescent care
- Residential care
- Assisted Living
- Group Homes

Psychological testing and Psychotherapy (including but not limited to):

- Subsequent Evaluations
- Subsequent Tests or Testing
- All Therapy
- All Biofeedback

The number to call to request one of these treatments is (888) 252-5075. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995 to notify them of my choice.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

Signature

Date

Printed Name

I live at:

Street Address

City

State

Zip Code

Name of Employer: _____

Name of Network: *Texas Star Network*[®]

Network service areas are subject to change. Call (800) 381-8067 if you need a network treating provider.

Please indicate whether this is the:

- Initial Employee Notification
- Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

NETWORK NOTICE

Texas Star Network®

To All Employees:

Your employer has chosen the Texas Star Network® to provide health care if you are injured at work. The Texas Star Network® is a certified workers' compensation health care network. This network includes medical providers that have been chosen to treat your work related injuries. They are easy to access and dedicated to giving you quality care. The following information will help you if you are injured at work.

- **If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility.**

The following applies if you are hurt at work and it is not an emergency.

- Tell your employer as soon as you can.
- Choose a treating doctor from the Texas Star Network® service area where you live.
- If you are a member of a health maintenance organization (HMO) at the time you are injured, you have the right to choose your HMO primary care doctor as your treating doctor. To do this, you must have chosen the doctor as your primary care doctor before your work related injury occurred. Texas Star Network® will approve this choice if your HMO doctor agrees to abide by the terms of the network contract and comply with required laws.
- You must obtain all treatment and referrals for your injury from your treating doctor.
- Your treating doctor will be paid by your workers' compensation insurer and will not bill you for treatment.
- If you receive treatment for your injury from providers who are not in the Texas Star Network®, you may have to pay for that care.
- Information about the Texas Star Network® is available by calling toll free (800) 381-8067 or by writing to Texas Star Network®, 3611 Queen Palm Dr. Ste. 200 ATTN: Client Services, Tampa, Florida 33619.
- A list of Texas Star Network® doctors is posted at the work site and is also available from your employer.
- You may be required to get certain treatments approved in advance. Treatment that requires this is listed in your network information materials. You may also request the list from your employer.
- If the doctor leaves the network and you have a life threatening condition or an acute condition you may continue to treat with a network doctor for 90 days. This must be requested by the doctor.

TEXAS STAR NETWORK®

EMPLOYER INFORMATION FORM

Welcome To Your Workers Compensation Health Care Provider Network Program.

Your insurance carrier has chosen the Texas Star Network®, a workers compensation health care network certified by the State of Texas, to offer a workers' compensation health care provider network program. The necessary materials to implement the program are enclosed to help prepare you when an injury occurs.

Components Of Program:

- Preferred provider network
- Employee educational materials
- Toll-free first report of injury
- Utilization management (Pre-authorization)
- Telephonic and on-site case management (may include vocational services)
- Complaint process

Employer Instructions:

- Read the enclosed network educational materials and post the **"Notice of Network"**.
- Distribute network educational materials when initiating the program, within 3 days of hiring an employee and at the time of injury.
- Document the method of delivery of educational materials, to whom the materials were delivered, the location of the delivery and the date delivered.
- Be sure that all employees sign the **Employee Acknowledgment** letter and maintain it in employee's personnel file. An employee who refuses to sign remains subject to network requirements. Document a refusal to sign the acknowledgment in the employee's personnel file.
- Review the provider panel postings to ensure that the suggested medical providers are within the geographical service area of the worksite. You may call the Texas Star Network® at (800) 381-8067 for additional doctors.
- When an injury occurs, report it immediately to your claims administrator. If necessary, provide or arrange transportation of the injured employee to the network provider, or if appropriate, to the nearest emergency facility.