SOUTH TEXAS DENTAL

(For Dentists, Dental Hygienists and Dental Assistants)

2017 TEXAS MUTUAL WORKERS' COMP INSURANCE

POLICY # TSF0001297883

Workers' Compensation Claim Instructions

1. Complete the Employer's First Report of Injury form.

2. Report the incident to Texas Mutual Insurance by using only 1 of the following 4 methods:

   - ✓ Online: www.texasmutual.com
   - ✓ Phone: Call (800) 859-5995, and follow prompts to report the workers' comp incident.
   - ✓ Fax: (877) 404-7999 (Managers, please print the fax confirmation showing date, time and fax number when the Employer's First Report was faxed to Texas Mutual.)
   - ✓ Mail to: Texas Mutual Insurance Company
     P.O. Box 12029
     Austin, TX 78711-2029

3. Send employee promptly to be checked by a doctor. The employee must choose a treating doctor from the Texas Star Network, to receive coverage of costs for care of work-related injury.

4. Please send a copy of the Employer's First Report of Injury, and the signed and dated Employee Acknowledgment Form to Human Resources c/o Maryann Sanguyo's email: asanguyo@southtexasdental.com, on the date of injury or as soon as possible. Please also provide copies of employee's exam results and updates on the employee's treatment/doctor's visits from the treating facility or doctor. File your copy in a confidential "Workers' Comp" file, at your office.

Continuation of 2017 STDA Workers' Compensation Claim Instructions

5. Give employee a copy of the injury report and the "Employee's Rights and Responsibilities" brochure.

6. Keep accurate records of the dates when you take any claim-related action, including when you file a supplemental report of injury (DWC-6 form).

When reporting a claim, you will need to provide the following information on the employer's first report of injury form:

1. Company Name: South Texas Dental

2. Company Address: 6300 West Loop South, Ste. # 650
Bellaire, TX 74041

1/31/17

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

Revised May 2015

Confirmación del Empleado de la Red de Compensación para Trabajadores

He recibido la información que me informa cómo obtener atención médica bajo el seguro de compensación para trabajadores de mi empleador.

Si sufro una lesión en el trabajo y vivo en un área de servicios descrita en esta información, comprendo que:

1. Debo elegir un médico de tratamiento de la lista de médicos de la red. O podría solicitarle a mi médico de cabecera de la OMS que acepte atenderme como médico de tratamiento. Si elijo a mi médico de cabecera como a mi médico del tratamiento, llamaré a Texas Mutual al (800) 859-5995 para notificarles mi opción.
2. Debo dirigirme a mi médico de tratamiento para todos los servicios de atención médica relacionados con mi lesión. Si necesito un especialista, mi médico de tratamiento me dará la derivación. Si necesito atención de emergencia podré dirigirme a cualquier lugar.
3. La compañía de seguros abonará los costos del médico de tratamiento y de los otros proveedores de la red.
4. Podría tener que abonar la factura si recibo asistencia médica en cualquier otro lugar que no sea un médico de la red, si no cuento con la aprobación de la red.
5. A sabiendas hacer un reclamo falso de compensación puede dar lugar a una investigación penal que podría resultar en sanciones penales, como multas y encarcelamiento.

_____ _____

Firma Fecha

_____

Aclaración

Vivo en: _____

Dirección

_____

_____

Ciudad Estado Código Postal

Nombre del Empleador: _____

Nombre de la Red: *Texas Star Network®*

Las áreas de servicio de la red se encuentran sujetas a cambios. Llame al (800) 381-8067 si necesita un proveedor de tratamientos médicos de la red.

Por favor, indique si la presente es la:

- ☐ Notificación Inicial
- ☐ Notificación de una Lesión (Fecha de la lesión: __/____/____)

NO ENTREGUE ESTE FORMULARIO A TEXAS MUTUAL INSURANCE COMPANY EXCEPTO QUE SE LO SOLICITEN.

Revisado en mayo de 2015

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 ☐ M ☐
3. Social Security Number
4. Home Phone ( )
5. Date of Birth (m-d-y)
6. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box / City / State / Zip Code / County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
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

15. Date of Injury (m-d-y)
16. Time of Injury : am ☐ pm ☐
17. Date Lost Time Began (m-d-y)
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site / Street or P.O. Box / City / State / Zip Code / County
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 ☐ NO ☐
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 ☐ NO ☐
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 ☐ NO ☐

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 ( ) / City / State / Zip Code
43. Business Location (If different from mailing address) Number and Street / 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 ☐ no ☐
If so, identify contact person and phone # _____

6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date _____ no ☐

7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐

8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date _____ no ☐

9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

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

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
☐ 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 (last 4 digits) xxx-xx- | 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 ☐ no ☐
If yes, the date of the 8th day (mm/dd/yyyy) _____

18. Date of most recent RTW _____
☐ Full duty, full pay
☐ Limited duty, full pay
☐ Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
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 ☐ no ☐

20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week
Indicated hours are:
☐ Increase from pre-injury
☐ Same as pre-injury
☐ Decrease from pre-injury

21. Weekly/hourly earnings for the pay period of _____ to _____ : $ _____ weekly or $ _____
Indicated wages are:
☐ Increase from pre-injury wage
☐ Same a pre-injury wage
☐ 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

OPTUM®

Pharmacy Benefits
for Injured Workers on the Job

TexasMutual® Insurance Company

Pharmacy Benefits for Injured Workers on the Job

Texas Mutual Insurance Company has chosen **Optum** to provide workers' compensation pharmacy benefit management services to their policyholders. This service assists injured employees in obtaining the medications they need, when they need them.

Injured employees will receive a pharmacy card directly from Optum to use for prescription services within a wide network of participating pharmacies. Accompanying the pharmacy card will be a letter explaining the benefits and how to use their card. Optum will issue a pharmacy card automatically once Texas Mutual Insurance receives notice of a claim.

If your injured employee requires a prescription before receiving a pharmacy card, you should complete and deliver the enclosed First Fill form. The injured employee may present a copy of the form to any participating pharmacy. This form allows the injured employee to receive a seven-day supply of covered medication without any out- of-pocket expense. To locate a participating pharmacy, simply visit Texas Mutual's website for a listing of participating pharmacies at www.texasmutual.com/hcn/hcn.shtm or visit www.cypresscare.com for a national listing of participating pharmacies.

Please keep the enclosed First Fill form as your master copy and make photocopies for distribution.

Injured employees may request replacements for lost or destroyed pharmacy cards by calling Optum at 1-888-220-2805; available 24 hours a day, seven days a week.

If you have questions regarding pharmacy benefits, contact Optum at 1-888-220-2805.

OPTUM®

Sandra Hugall
Client Service Specialist,
Account Management

10050 Banburry Cross Dr., Ste 290
Las Vegas, NV 89144
P 678-347-2428

Sandra.Hugall@optum.com

Policyholder Information

OPTUM®

Network Pharmacies
Texas

TexasMutual® Insurance Company

Summary of Network Pharmacies Texas

For additional network pharmacies:

- Call Optum at 1-888-220-2805
- Fax 1-800-419-7194
- Visit www.texasmutual.com/hcn/hcn.shtm

To enroll in the Optum mail order program, you need:

1. Claim number
2. Prescription number
3. Doctor's name and phone number
4. Medication name
5. Prior pharmacy's name and phone number

For more information on home delivery services, call Optum at 1-888-220-2805.

Your prescription will be delivered to your home in three days or less.

Policyholder Information

OPTUM®

Prescription First Fill Form

TexasMutual® Insurance Company

Prescription First Fill Instructions

1. Participating Optum pharmacies include Walgreens, CVS, Walmart, Kroger, Target, Costco, Sam's Club, Brookshire, HEB and Tom Thumb. To locate other participating pharmacies, visit www.texasmutual.com/hcn/hcn.shtm or www.cypresscare.com.
2. Complete the form and take to the pharmacy along with your prescription from the provider.
3. This form allows you to fill your initial prescription(s) with a maximum cost of $500 per covered prescription and a maximum 7 day supply.
4. If you have questions, please call us at 1-888-220-2805, available 24 hours a day, seven days a week.

Bin #: **Pharmacy to Call for BIN** Group Number: **TEXASMUTUALFF**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Policyholder Information

Pharmacy Help Desk: **1-888-220-2805**

PLEASE NOTE: This form is only **valid within 10 days** of the injury date. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive a pharmacy card, please call us **at 1-888-220-2805.**

Issuance of this letter or dispensing of a prescription does not constitute acceptance of your claim.

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.

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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 Counsel'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).

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que ayuda a los empleados que no cuentan con representación legal con sus reclamaciones en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-EZE-OIEC (1-866-393-6432). Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio Web de la agencia (www.oiec.texas.gov).

PROGRAMA DE OMBUDSMAN

¿QUÉ ES UN OMBUDSMAN? Un Ombudsman es un empleado de OIEC que puede asistirle si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita. Cada Ombudsman cuenta con una licencia de ajustador de compensación para trabajadores y ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation). Una vez que el procedimiento haya sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarle con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

Código Administrativo de Texas No. 28 (28 Texas Administrative Code –TAC, por su nombre y siglas en inglés) §276.5. Aviso del Empleador sobre el Programa de Ombudsman para los Empleados (A partir de 9/1/13)

(a) Todos los empleadores que participan en el sistema de compensación para trabajadores deberán mostrar el aviso sobre el Programa de Ombudsman de la Oficina de Asesoría Pública para el Empleado Lesionado (OIEC). Este aviso deberá ser mostrado en la oficina de personal, si es que el empleador cuenta con una oficina de personal, y en el área de trabajo donde cada empleado probablemente podrá ver el aviso de manera regular.

(b) Este aviso del Programa de Ombudsman deberá ser públicamente mostrado en inglés, español, y cualquier otro idioma que sea común para la población de los trabajadores del empleador.

(c) Este aviso deberá contener el texto que es proporcionado por OIEC sin ninguna palabra adicional o cambios y se puede obtener:

(1) Descargando el formulario del sitio Web de OIEC en: www.oiec.texas.gov, o

(2) Solicitando el aviso llamando al número de teléfono gratuito de OIEC al: 1-866-EZE-OIEC (1-866-393-6432).

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] STX HEALTHCARE MANAGEMENT SERVICES has workers' compensation insurance coverage from [name of commercial insurance company] TEXAS MUTUAL in the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] 11/30/2016. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] TEXAS MUTUAL. 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 WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] SOUTH TEXAS DENTAL has workers' compensation insurance coverage from [name of commercial insurance company] TEXAS MUTUAL in the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] 11/30/2016. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] TEXAS MUTUAL. 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.

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