EMPLOYEE NOTICE OF NETWORK REQUIREMENTS

Majoris Health Systems, Inc. is a certified Workers' Compensation Network focused on the improvement of clinical outcomes to Texas injured workers.

Our mission is to provide personable, comprehensive, superior health care, customer service, and managed care services developed by the cooperative efforts and input from employees, network providers, employers, insurance carriers, and community leaders.

I. How to Reach Us

For additional information about Majoris Health Systems' participating providers, please see below.

Note: All of this information is available in electronic format at www.majorishealthsystems.com or by e-mail at your request.

Office Hours:
Monday through Friday 9:00 am to 5:00 pm Central Standard Time

Phone: 503-639-6080
Toll Free: 1-877-304-9526

Fax: 503-601-8437

Address: Majoris Health Systems
PO Box 1728
Lake Oswego, OR 97035

Email Address: info@majorishealthsystems.com
Website: www.majorishealthsystems.com

Frequently Asked Questions

1. What is a Workers' Compensation Network?

A Workers' Compensation Network is an organization which must be certified by the Texas Department of Insurance to contract with doctors, hospitals, and other healthcare providers to provide services to injured workers who are accessing the network.

2. How do I know if I am eligible to be enrolled in the Majoris Health Systems Workers' compensation network?

You must live within the Majoris Health Systems network geographic service area. An injured worker who sustains a new injury and meets the following criteria is eligible to participate in the network:

- Injury occurs on or after 9/01/05; and
- Injury occurs after the effective date of the contract between the insurance carrier and Majoris.

3. Who can be attending physician under the Majoris Health Systems network?

Under Texas law, an attending physician is called a treating doctor. Majoris Health Systems treating doctors are all medical doctors (M.D.), or a doctor of osteopathy (D.O.). The treating doctor specialties are: Family Practice, General Practice, Internal Medicine, and Occupational Medicine.

4. What does the treating doctor do?

A treating doctor is the primary doctor you will select from the Majoris Health Systems Treating Doctor List to provide and/or coordinate all aspects of your medical care and oversee the course of treatment to ensure that proper care is maintained. All health care and referrals are provided by the treating doctor. Information on selecting a treating doctor can be found under "Network Requirements."

5. Can I change my Treating Doctor?

Under Texas law you can change your treating doctor once after your initial choice, but you must choose an alternate treating doctor within the Majoris Health Systems network. To learn more about choosing an alternate treating doctor, see "Network Requirements."

6. Will I be able to see my family physician for my work injury?

Yes, if you are a HMO member and have already selected a physician as your primary care doctor under the HMO plan. The primary care doctor, if not contracted with the Majoris Health Systems network, must agree to the terms and conditions of the Majoris Health Systems provider agreement, comply with the Majoris Health Systems treatment guidelines, protocols, and Texas Insurance Code 1305, relating to quality improvement and credentialing. If you do not have an HMO primary care doctor, you must select a Majoris Health Systems network treating doctor from the list provided.

7. My personal physician is a chiropractor who is not on the Majoris Health Systems network. If I am injured on the job and enrolled in Majoris Health Systems, will I be able to treat with this chiropractor?

No. In non-emergency cases, you must first seek treatment from a Majoris Health Systems treating doctor. The treating doctor will refer you to any specialist that may be required.

8. If I refuse to go to any physician in the Majoris Health Systems network and choose not to participate in the program, what will happen to my claim?
If you do not comply with the Majoris Health Systems network requirements after you have been informed of them by receipt of the Employee Notice Network Requirements and you have a work related injury claim, your insurance carrier has the right to deny payment of the claim. You may be responsible for payment of all services performed outside the network guidelines.

9. What is a service area?
The service area is the state-certified geographical area where Majoris Health Systems has contracted with network providers to serve the employees who live in that geographical area.

10. Can my treating doctor or other Majoris Health Systems providers bill me for any of the expenses?
No, as long as you are using Majoris Health Systems network providers and the claim is eligible and compensable, you will not be billed for any treatment related to your workers' compensation claim.

11. Am I responsible for calling Majoris Health Systems to get pre-authorization before I have surgery or other necessary treatment?
Only in some cases. Your Majoris Health Systems provider is responsible for notifying the network when you need treatment that requires pre-authorization. If the provider fails to contact Majoris Health Systems for pre-authorization, you will not be billed for the treatment, even if the insurance carrier denies payment to the provider.

However, YOU are responsible for obtaining approval from Majoris if you would like to change treating doctors, need to be referred to a specialty provider, or an out-of-network provider. If you fail to contact Majoris for approval, you may be billed for such services.

Network Requirements

II. Treating Doctors

All health care services and referrals must be provided by the Majoris Health Systems treating doctor if you live inside the Majoris Health Systems service area (except for emergency services).

2.1 Selection of a Treating Doctor

The selection of a treating doctor is crucial for immediate coverage in the network. For each injury, you will select a treating doctor in the service area from a list of participating providers provided by Majoris Health Systems. If prior to the injury you had selected an HMO primary care physician, you may request that the provider be approved to treat you for your workers' compensation injury. Your HMO

primary care physician must agree to treat you as a workers' compensation patient and abide by the Majoris Network Requirements.

2.2 Non-Primary Care Treating Doctor

If you have a chronic, life-threatening injury, or a chronic pain related to a workers' compensation injury, you may request that a Majoris Health Systems network specialist serve as the treating doctor. In order for the specialist to become the treating doctor, there must be a medical need certified by the specialist, and the specialist must agree to accept the responsibility to coordinate your health care needs. If Majoris Health Systems denies the request, you may appeal through the internal complaint resolution process.

III. Changing Treating Doctors

3.1: Alternate Treating Doctor

If you are dissatisfied with your initial choice of a treating doctor, you are entitled to select an alternate treating doctor from the Majoris Health Systems Treating Doctor List who provides services within the service area in which you live. You may only select an alternate treating doctor one time. To select an alternate treating doctor, you must complete a Majoris Health Systems Treating Doctor Selection Form, available by calling Majoris Health Systems.

If you are then dissatisfied with the alternate treating doctor, you must obtain authorization from Majoris Health Systems to select any subsequent treating doctor. Majoris Health Systems will follow procedures and criteria to be used in authorizing you to select subsequent treating doctor. Denial of a request for any subsequent treating doctor is subject to the Majoris Health Systems appeal process.

3.2: Changes in Treating Doctor Exceptions

For purposes of this section, the following do not constitute the selection of an alternate or any subsequent treating doctor:

1. A referral made by the treating doctor, including a referral for a second or subsequent opinion;
2. The selection of a treating doctor because the original treating doctor dies, retires, or leaves the network; and
3. A change of treating doctor required because of a change of address by the employee to a location outside the service area.

IV. Service Areas

4.1: Regional Service Area Description

Majoris Health Systems is certified to provide services in the following geographic service areas:

- Dallas/Ft. Worth area counties: Collin, Dallas, Denton, Rockwall, Tarrant
- Austin/San Antonio area counties: Bexar, Caldwell, Lee, Medina, Travis, Williamson
- Brownsville/McAllen/Harlingen area counties: Hidalgo, Cameron
- Seguin/Schertz area county: Guadalupe
- Laredo area county: Webb

The Majoris Health Systems Provider Directory is available to you in electronic format at www.majorishealthsystems.com, by e-mail, and paper copy upon request. A map of the service area is provided with the Majoris Health Systems Provider and Treating Doctor Lists. The Majoris Health Systems Provider and Treating Doctor Lists are updated quarterly. Providers are grouped by specialty and treating doctors are listed separately from specialists. Referrals to specialists must be made through the treating doctors and/or be preauthorized by Majoris Health Systems.

In addition to the provider name, address, and telephone number, the following information will be clearly identified for each provider:

1. Providers who are authorized to assess maximum medical improvement and render impairment ratings;
2. Providers with any limitations of accessibility and referrals to specialists; and
3. Providers who are accepting new patients.

If you live within the counties identified as the Majoris Health Systems service area, you must obtain medical treatment for covered work-related injuries only by a Majoris Health Systems participating provider, except as provided under the Majoris Health Systems Out-of-Network Services Policy.

You are considered to "live" within the Majoris Health Systems service area if you:

- Live permanently in the Majoris Health Systems service area (the physical address you represented to your employer);
- Live at a temporary residence necessitated by your employment; or
- Live in a temporary residence taken for the purpose of receiving necessary assistance with routine daily activities because of a compensable injury.

4.2: Live Outside the Service Area

If you believe you do NOT live within the Majoris Health Systems service area, you may request a review by notifying your insurance carrier. The insurance carrier will issue a written determination of its decision within 7 calendar days. If the insurance carrier determines that you do live within the service area and you disagree with this determination, you may file a complaint with the Department of Insurance as described in Section XII of this notice. During the review process, you may seek all medical care from Majoris Health Systems network providers, but you are not required to do so. Please be aware that should you choose to seek medical care from providers outside the Majoris Health Systems network, and ultimately it is determined that you do live within the service area, you may be liable for the payment of those services received outside the network.

V. Majoris Health Systems Network Services

If you live inside the Majoris Health Systems network service area, you must receive all medical treatment from a Majoris Health Systems participating provider unless indicated below in "Out-of-Network Services."

VI. Out-of-Network Services

6.1: Out-of-Network

You are allowed to receive medical treatment out of network if

- You require emergency care;
- You do not live within the service area; or
- Your treating doctor refers you to an out-of-network provider and that referral has been approved by Majoris Health Systems.

6.2: Emergency Care

An emergency is a medical or mental injury or the sudden onset of an illness that may endanger your life or cause permanent impairment.

- Medical emergency means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity. This includes: severe pain, that the absence of immediate medical attention could reasonable be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

- Mental health emergency means a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

In the case of a true emergency, you should call 911 or go to the nearest hospital.

6.3: After-Hours and Urgent Care

For non-emergency urgent health care or after hours, please go to the nearest Majoris Health Systems urgent care facility or call Majoris Health Systems immediately for assistance. Majoris Health Systems urgent care (24 hour) facilities are available to provide advice and treatment of urgent health problems 24 hours a day, 7 days a week, and 365 days a year. Urgent health problems (physical or emotional) include sudden, serious, and unexpected illnesses, injuries, or conditions which require immediate attention.

Nights, weekends and holidays, call Majoris Health Systems after-hours urgent care at **1-877-304-9526** if you think you need urgent care (physical or emotional) when other health services are closed. After-hours urgent care is staffed by a team of physicians, nurse practitioners, nurses, medical assistants, and administrative staff ready to meet your needs for urgent care. Please understand that patients with more serious conditions may be seen before others.

If you have a very serious condition that cannot be fully evaluated or treated at a Majoris Health Systems urgent care facility, we will arrange to transfer you to a hospital emergency room. In the event that you are transferred, be sure to contact Majoris Health Systems.

6.4: Live Outside the Service Area

If you believe you do NOT live within the Majoris Health Systems service area, you may request a review by notifying your insurance carrier. If the insurance carrier determines that you do live within the service area and you disagree with this determination, you may file a complaint with the Department of Insurance as described in Section XII of this notice. During the review process, you may seek all medical care from Majoris Health Systems network providers, but you are not required to do so. Please be aware that should you choose to seek medical care from providers outside the Majoris Health Systems network, and ultimately it is determined that you do live within the service area, you may be liable for the payment of those services received outside the network.

6.5: Referral to Out-of-Network Provider
A treating doctor will request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by Majoris Health Systems.

VII. Billing/Payment for Services

7.1: Majoris Health Systems Participating Providers Billing
Majoris Health Systems participating providers are required to bill the insurance carrier for all health care services provided to you. Majoris Health Systems participating providers will not bill you for any services related to an eligible and compensable injury.

7.2: Out-of-Network Providers Billing
If you receive treatment from an out of network Provider without prior approval by Majoris Health Systems, you may be responsible for the full payment of services received by the out of network Provider.

You are NOT responsible for payment of treatment received by an out of network provider if:

- You receive a Majoris Health Systems approved referral from a Majoris Health Systems treating doctor;
- Due to emergency care; or
- If you live outside the Majoris Health Systems service area. (If after review the insurance carrier finds that you do live within the service area, you may be responsible for payment of services received by an out-of-network provider).

VIII. Coordination of Timely Care
Majoris Health Systems participating providers and employees are required to coordinate care, provide services, and be accessible to you on a timely basis. This includes initial evaluation, ongoing treatment, referrals to specialists, responsiveness to inquiries or complaints, medical management, utilization review, and case management. Except for emergencies, Majoris Health Systems will arrange for covered health care services, including referrals to specialists, to be accessible to an employee on a timely basis upon request and within the time appropriate to the circumstances and condition, but not later than 21 days after the date of the request.

IX. Continuity of Care
Majoris Health Systems provides for continuity in care if your health could be jeopardized if medically necessary covered services are disrupted or interrupted. Majoris will assist you with the coordination of any transition of care from an out-of-network provider to a Majoris Health Systems participating provider, or from a Majoris Health Systems participating provider who terminates with the network to an active Majoris Health Systems participating provider.

In the event a treating doctor is terminated from the network, Majoris will notify you as soon as reasonably possible to assist you in selecting a new treating doctor within the network panel. Majoris will provide you a listing of available treating doctors in your area and ensure that all medical records are transferred immediately. You will receive written notice from Majoris prior to the effective date of termination of any provider. In instances where prior notice is not possible due to the sudden death of a provider, Majoris will contact you immediately to arrange for the selection of a new treating doctor.

If a provider leaves the network and you are receiving care for a life-threatening condition or an acute condition for which disruption of care would harm you, the network will continue to reimburse the provider for a period not to exceed 90 days upon the provider's request, to ensure a safe transition while you select a new treating doctor. A dispute concerning continuity of care shall be resolved through the complaint resolution process outlined below. You will receive written notice from Majoris prior to the effective date of termination of the provider.

If you are being treated by an out-of-network provider, you may not be required to select a Majoris Health Systems treating doctor if Majoris Health Systems determines that changing physicians would be medically detrimental to you. You may be transitioned to a Majoris Health Systems participating provider when you become medically stationary, or it would no longer be medically harmful to change providers. In such cases, the Majoris medical advisor will review your proposed treatment plan and assist your treating provider in transitioning your care to a network provider.

X. Pre-Authorization

Pre-authorization determines whether medical services are medically necessary and provided in the appropriate setting or at the appropriate level of care. Pre-authorization requirements are a responsibility of the Majoris Health Systems participating provider, not you, the employee.

Out-of-network services always require pre-authorization. If no pre-authorization or referral is obtained for the out-of-network services, no benefits are available and out-of-network claims will be denied. See "Out-of-Network Services" for exceptions to this requirement. Majoris will respond to request for pre-authorization within the periods prescribed below:

- Within the 3rd working day for preauthorization requests;
- 24 hours of receipt for a request for concurrent hospitalization care; and
- Within 1 hour for post-stabilization treatment or a life-threatening condition.

Note: Failure to meet pre-authorization requirements may result in non-payment. Providers cannot bill or collect fees from employees for services. This list may not be revised without prior notification to providers and employees per applicable law.

10.1: Services Requiring Pre-Authorization

Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all non-exempted work hardening or non-exempted work conditioning programs;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;
(ii) Therapeutic procedures, excluding work hardening and work conditioning;
(iii) Orthotics/Prosthetics Management;
(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure codes; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury, or
(ii) a surgical intervention previously preauthorized by the carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:
(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline, or
(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the Division's formulary;

(12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier;

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the carrier pursuant to Labor Code §408.0042 and §126.14 (relating to Treating Doctor Examination to Define the Compensable Injury

XI. Complaint and Appeal Procedures

For general complaints, disputes or appeals, a party should contact Majoris Health Systems either by letter, e-mail, or telephone. All complaints and disputes must be submitted within 90 days of the date of the disputed action.

The complaint should be mailed to:

Majoris Health Systems
Employee Complaint Department
PO Box 1728
Lake Oswego, OR 97035
503-639-6080
E-mail: info@majorishealthsystems.com

Majoris Health Systems will acknowledge receipt of the complaint by letter within 7 calendar days and send an acknowledgment letter that will include a description of the complaint procedures, time frames, and a one-page complaint form for the appealing party to complete if the complaint is received verbally. At that time, a request will be made for any additional information that may be warranted to process the dispute. We are always available to discuss any of these items with you if you so wish.

After the network has investigated a complaint, Majoris shall issue a resolution letter to the complainant no later than the 30th calendar day after the network receives the written or oral complaint.

If the complainant is dissatisfied with the resolution of the complaint or the process, the complainant may file a complaint with the Texas Department of Insurance.

Majoris Health Systems shall not engage in any retaliatory action against an employee, employer, or provider because the employee, employer, provider, or any other person acting on behalf of the employer or employee has filed a complaint against the network.

XII. Adverse Determinations Utilization Review (Denials)

Adverse determination means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary, are experimental, or investigational.

Appeals arising from decisions made in the service utilization review process or quality assurance process must be made orally or in writing. The appeal or complaint may be made by the patient or someone acting on their behalf, or by the patient's physician or health care provider.

When a medical dispute arises, it is referred by the Majoris medical director to a member of the Medical Review Committee (MRC). This committee is comprised of physicians appointed by Majoris with appropriate expertise and specialties to review the treatment issue(s) in dispute and will not include the physician who made the original decision. The committee members will review the medical treatment issue and make a determination whether to uphold the decision, obtain additional information, or reverse the decision. Anytime additional medical information is required or obtained through the reconsideration process it will be included in the review.

An employee, a person acting on behalf of the employee, or the employee's requesting provider may no later than the 30th day after the date of issuance of written notification of an adverse determination

request reconsideration of the adverse determination either orally or in writing. The reconsideration process will be completed within 30 days of the date that Majoris receives the request. At the completion of the reconsideration process, Majoris will notify all parties in writing of the decision. Such notice will include an explanation of the reasons for the decision, including any medical or clinical basis for the decision, the credentials of any medical provider consulted in the process and the state(s) of licensure for those providers. The parties will also be advised of the right to seek review of a denial by an independent review organization. Such review may be requested through the completion of the forms allowing for the request of an independent review, which are included with this notice. The forms are also available on the Texas Department of Insurance website: www.tdi.state.tx.us or by sending a written request to:

HMO Division
Mail Code 103-6A
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

A request for an independent review must be filed no later than the 45th calendar day after the denial of reconsideration.

If you have any questions or need assistance in completing this form, you may contact Majoris Health Systems at the number below or contact the Texas Department of Insurance at the number provided on the form.

Majoris will promptly notify the Texas Department of Insurance when there has been a request for independent review. Notice will be made via electronic transmission and will be on the form required by the Texas Department of Insurance. The utilization review agent may access the Texas Department of Insurance on working days between 7:00 a.m. and 5:00 p.m., Central Standard Time, Monday through Friday, to obtain assignment of an independent review organization.

The Texas Department of Insurance will then advise Majoris and the patient of the independent review organization assigned to the case. Within three days of that notification, Majoris must provide the following to the independent review organization:

- All relevant medical records relating to the issue in dispute;
- Any documents relied upon for the utilization review decision by Majoris;
- A copy of the notification of the results of the internal review by Majoris;
- Any information provided to Majoris to support the appeal; and
- A list of names and phone numbers of any health care provider who has provided treatment and/or may have records relevant to the appeal.

After an independent review organization's review and decision under this section, a party to a medical dispute that disputes the decision may seek judicial review of the decision. The Division of Workers' Compensation and the Department are not considered to be parties to the medical dispute. A decision of an independent review organization related to a request for pre-authorization or concurrent review is binding. The carrier is liable for health care during the pendency of any appeal, and the carrier and network shall comply with the decision.

If judicial review is not sought under this section, the carrier and network shall comply with the independent review organization's decision.

XIII. Special Appeal Rights

Parties will be entitled to expedited reconsideration procedures for denials of pre-authorization of treatment involving post-stabilization treatment, life-threatening conditions, or denials of continued stays for hospitalized employees. Such requests will be reviewed in the same manner as listed above, but a response will be provided within one working day from the date of receipt of all information necessary to complete the reconsideration.

A patient with a life-threatening condition is not required to complete the reconsideration process, but may proceed directly to a request for independent review. The enrollee, person acting on behalf of the enrollee, or the enrollee's provider of record shall determine the existence of a life-threatening condition.

If you believe you qualify and want to request review by an independent review organization, you may do so at no cost to you. The Texas Department of Insurance will randomly assign an independent review organization to your case and will notify us within one day of that assignment. We will then provide all of the necessary medical records for your case to the independent review organization for their consideration.

XIV. Appeals of Adverse Determinations (Denials)

To ensure timely response to an appeal, please include the following information and submit to:

The JI Companies
P.O. Box 26655
Austin, Texas 78755-0655
(512) 346-9321

The following information should be included in the appeal:

- Your full name;
- Social Security number;
- If appealing party is not the enrollee, include the full name and relationship to the enrollee;
- Dates of service during which appeal took place, if applicable;
- Place where service(s) took place, i.e., hospital, doctor's office, radiology, home health visit at home, etc. if applicable;
- If appeal is for emergency room services, please a send copy of the emergency room record; and
- Provide a brief description of the incident, including names, dates and times that will support resolution of the appeal.

XV. Complaints to Texas Department of Insurance

Anyone may submit a complaint to the Texas Department of Insurance.

Send complaint to:

Texas Department of Insurance
HMO Division, Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104
Toll Free: 1-800-252-7031
Fax: 512-490-1012

You may use the online complaint form at www.tdi.state.tx.us.

Send email complaints to: hmonewcomplaints@tdi.state.tx.us or consumerprotection@tdi.state.us.