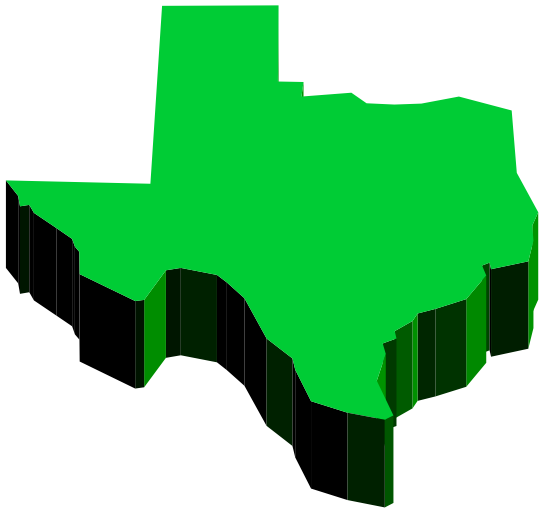
EMPLOYEE NOTIFICATION
OF
NETWORK REQUIREMENTS



IMPORTANT INFORMATION

FROM YOUR

LIBERTY

HEALTH CARE NETWORK

October 2009

Keep this handy for future reference

MEDICAL TREATMENT FOR WORK RELATED INJURIES

Your employer provides medical care for work related injuries through the Liberty Health Care Network (The Network). The Network is certified as a health care network by the State of Texas.

This document tells you what you need to know about this program.

NETWORK SERVICE AREA

The Network's Service Area includes the following counties: Atascosa, Austin, Bandera, Bastrop, Bexar, Blanco, Brazoria, Brazos, Brooks, Burleson, Burnet, Caldwell, Cameron, Chambers, Collin, Dallas, Delta, Denton, Duval, Ector, Ellis, El Paso, Frio, Fort Bend, Grimes, Hardin, Harris, Henderson, Hidalgo, Hill, Hood, Hopkins, Howard, Hunt, Jefferson, Jim Hogg, Jim Wells, Johnson, Kaufman, Kendall, Kenedy, Kleberg, Lampasas, Liberty, Lubbock, Madison, Medina, Midland, Montgomery, Navarro, Nueces, Parker, Polk, Potter, Rains, Randall, Rockwall, San Jacinto, Smith, Somervell, Tarrant, Taylor, Tom Green, Travis, Trinity, Tyler, Van Zandt, Walker, Waller, Washington, Willacy, Williamson, Wilson, Wise, and Wood.

Attached to this document is a map of the Service Areas.

You will have access to hospitals, specialists, and treating doctors who are available twenty-four (24) hours a day, seven days a week.

If you do not live in a rural area:

- your treating doctor or hospital will be no more than 30 miles.
- access to specialist or specialty hospital will be no more than 75 miles.

If you live in a rural area:

- your treating doctor or hospital will be no more than 60 miles.
- access to specialist or specialty hospital will be no more than 75 miles.

If you think you live outside the Service Area:

- tell your employer and call your Network Representative for review.
- You can receive care from the network during this review

- A reply will be sent within seven (7)days of receiving your request for review.

If you are found to live in the Service Area you must choose a treating doctor from the network.

If you receive care outside the network and you are found to live in the Service Area you may be responsible for those charges.
If you do not agree with the decision, you may file a complaint with the Texas Department of Insurance by contacting them at www.tdi.state.tx.us or by writing to:

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

Include the following:

- your name
- current address
- telephone number
- a copy of the Network's letter, and
- anything else you sent to the Network with your request.

SELECTION OF A TREATING DOCTOR

If you are injured on the job and need medical care you must choose a doctor to manage all of your medical needs.

You have two ways to choose a treating doctor.

1. Choose your current HMO doctor (doctor listed as your treating doctor under your health insurance plan)
    a. as long as that doctor was chosen as your HMO doctor prior to your work injury AND
    b. your HMO doctor agrees to the terms of the Network and will comply with the Network rules.

    You should contact your Network Representative to discuss this request

OR

2. You may choose a doctor in your service area from the network labeled as "Treating Doctors". The Network provider list will be available to your employer, your doctor and you. You may ask your employer or Network Representative for a copy of a full or partial list of doctors or get a copy by

a. an internet link OR
b. by calling 1-800-944-0443

If you are using the internet, simply enter www.libertymutualprs.com in the address box of your computer's search engine. Click on the "Provider Search" tab and enter the address from which you like the search to be conducted.

If you are currently treating for a work injury by a doctor not in the network you must select a doctor in the network. This has to be done within fourteen (14) days after you receive this notice. If you do not select a Network doctor within that time, the Network will assign one to you.

Except for emergency services, you must obtain all health care and specialist referrals through your treating provider.

The Network must arrange for timely medical treatment, including referrals to specialists. This means not more than twenty one (21) days after receiving your request. This does not include Emergency treatment.

Change of Treating Doctor

If you want to change your treating doctor you must contact your Network Representative. They will help you get a list of doctors in your Service Area.

If you are not happy with your second choice you must contact your Network Representative for approval to change your doctor. If your request is denied you may appeal the decision through the Network complaint process. See the heading "How to File A Complaint" in this document.

Call your Network Representative if your treating doctor dies or leaves the network. If you move outside the service area or distance requirements you may choose a new doctor.

Referrals To Specialists

Treating doctors may refer you to specialists within the network. If your treatment needs cannot be met within the network your Network Representative must approve out of network referrals. They must respond within seven (7) days from receipt of your request.

Request To Use A Specialist as a Treating Provider

If you want a Specialist to be your treating doctor, please contact your Network Representative for additional information.

EMERGENCY TREATMENT

The Network will allow for treatment outside the network for:

- emergency treatment received during or after work hours. This is only until the doctor allows you to go home or return to work.
- Business travel puts you temporarily out of the Service Area.

You must notify your employer within 48 hours of treatment. Any follow up treatment must be done by a Network doctor.

CONTINUITY OF CARE (Continuing Care) POLICY

If your doctor voluntarily leaves the Network and requests to continue your care the Network will reimburse the provider for no more than ninety (90) days, at the contracted rate, for:

- treatment for an acute condition if a change would cause you harm
- treatment for a life-threatening condition if a change would cause you harm

This policy shall not require the Network to provide for continued treatment by a provider whose contract with the Network has been terminated or not renewed due to:

- medical disciplinary action
- failure to maintain or keep a license, OR
- any other reason for which continuation of care with that provider could risk your health or safety.

Disputes shall be resolved through the Network's complaint process. See the heading "How to File A Complaint" in this document.

PREAUTHORIZATION AND CONCURRENT REVIEW REQUIREMENTS

For certain services your doctor must obtain prior approval. Below is a list of those services:

- Inpatient hospital admission including the principal scheduled procedure(s) and the length of stay

- Outpatient surgical or ambulatory surgical services
- Spinal surgery
- Psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program
- Repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than $350 or without a reimbursement rate established in the current Medical Fee Guideline.
- Work hardening and work conditioning services provided in a facility that has not been approved for exemption by the Commissioner.
- Chronic pain management/interdisciplinary pain rehabilitation
- Durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental).
- 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
- Physical and occupational therapy 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 code; 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 the date of injury or a preauthorized surgical intervention.

- Drugs not included in the Division's formulary; •
- Treatments and services that exceed or are not addressed in the ODG treatment guidelines and are not contained in a preauthorized treatment plan
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<u>Some treatment will be reviewed as you receive it. Below is a list of those services:</u>

- Inpatient length of stay
- Work hardening or work conditioning services
- Physical and Occupational Therapy services
- Investigational or experimental services or use of devices
- Chronic Pain Management/Interdisciplinary Pain Rehabilitation programs
- Required Treatment Plans

Emergency treatment does not need prior approval.

You or your doctor may request prior approval for a listed service. Your doctor may request approval for a treatment plan that is not listed or outside the Network guidelines..

The Network will send a written decision to your or your provider.

Appeal Process

You may appeal a denial. It must be done no later than thirty (30) days after the denial was sent.

Your Network Representative can explain the process and provide a copy of the Network's procedures.

If the denial is upheld, after your appeal, you or your provider may seek review by an independent review organization (IRO).

Complaint Process

Complaints will be handled by the Network's complaint process. See Section, "How to File a Complaint."

PAYMENT OF MEDICAL BILLS

Network providers will bill the Network for in-network services. You will not be billed.

If you received approval for out of network treatment or emergency care for a work injury, the Network will pay those bills.

You may be responsible to pay for all other services outside the Network.

HOW TO FILE A COMPLAINT

If you are not satisfied with the Network or its providers, you may file a complaint.

Contact the Network's Manager to submit your complaint. This can be done over the phone or by mail.

You may mail your complaint to: Liberty HCN
ATTN: Claims Manager
2100 Walnut Hill Lane

Irving, TX 75038

Or you may submit your complaint by e-mail to: TexasNetwork@libertymutual.com

Complaints must be made no later than 90 days after the issue arises.

Complaints or Appeals will not be held against you or your provider.

If you are still not satisfied, you may submit a complaint to the Texas Department of Insurance. Claim forms may be obtained from the Department's website at www.tdi.state.tx.us or the HMO Division, Texas Department of Insurance, Mail Code 103-6A, P.O. Box 149104, Austin, TX 78714-9104.

NETWORK CONTACT INFORMATION

Should you require additional information about the network, including information about network providers, please contact the Liberty HCN at:

Liberty Health Care Network
ATTN: HCN Network
2100 Walnut Hill Lane
Irving, TX 75038

Liberty Provider Referral Line, 1-800-944-0443 (toll free-24 hours)
Requests for Preauthorization and Concurrent Review, 1-800-664-2273 (toll free-24 hours)