TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

INVOICE

Tyler County
Attn: Jackie Skinner
PO BOX 2039
Woodville, TX 75979

Invoice Due Date: January 1, 2023
Invoice #: NRCN-38094-WC1
Coverage #: WC-2290-20230101-1
Coverage Period: January 1, 2023 - January 1, 2024
Member Number: 2290

Coverage	Description	Contribution
Workers' Compensation	1st Quarterly Installment	$15,660
TOTAL DUE		**$15,660**

Installment	Invoice#	Amount	Due Date
1st Quarterly	NRCN-38094-WC1	$15,660	January 1, 2023
2nd Quarterly	NRCN-38094-WC2	$15,660	April 1, 2023
3rd Quarterly	NRCN-38094-WC3	$15,660	July 1, 2023
4th Quarterly	NRCN-38094-WC4	$15,659	October 1, 2023
	Total Contribution	$62,639	

Payment Remittance Form

Tyler County
Attn: Jackie Skinner
PO BOX 2039
Woodville, TX 75979

Invoice Due Date: January 1, 2023
Invoice #: NRCN-38094-WC1
Payment Due: $15,660

Amount Enclosed: _____

If the total amount enclosed is not $15,660, please use the notes section below to explain:

_____

_____

_____

Please make checks payable to:

Texas Association of Counties Risk Management Pool
Box # 2426
San Antonio, TX 78298-9900

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

WORKERS' COMPENSATION
INVOICE SUMMARY

Member Name: Tyler County

Coverage Period: January 1, 2023 - January 1, 2024

SUMMARY	
Pool Target Modifier	0.92
Multi-line Discount	-$16,312
Alliance Participation Discount	-$2,610
2023 Estimated Workers' Compensation Contribution	$62,639

BREAKOUT

Class Code	Class Code Description	Number of Employees	Estimated Payroll	Cost Allocation Factor	Contribution
090140	Bldg. Maintenance & Janitors	6	$243,814	1.946353	$4,745
088100	Clerical	44	$2,063,314	0.133287	$2,750
088110	Election Personnel	3	$8,037	0.133287	$11
087420	Juv Probation, Collectors, Sales	2	$153,400	0.305525	$469
077200	Law Enforcement	38	$1,923,779	1.493543	$28,732
088200	Law Office	6	$340,229	0.044429	$151
055060	Road Employees-Paving, Repaving	27	$1,602,500	1.584835	$25,397
088310	Vet Hospital & Animal Control	1	$6,579	2.502019	$165
088550	Volunteers - Fire Fighters	1	$5,618	3.892098	$219
	Total Payroll/Employees	128	$6,347,270		$62,639

FINANCIAL SUMMARY	
2023 Estimated Workers' Compensation Annual Contribution	**$62,639**
2023 Estimated Workers' Compensation Prorata Contribution	**$62,639**

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Workers' Compensation
Contribution & Coverage Declaration

Named Member: Tyler County

Coverage Period: January 1, 2023 through January 1, 2024

This Contribution & Coverage Declaration (CCD) is part of the Coverage Documents between the Texas Association of Counties Risk Management Pool (Pool) and the Named Member shown above, subject to the terms, conditions, definitions, exclusions, and sublimits contained in the Coverage Documents, any endorsements, and the Interlocal Participation Agreement (IPA).

WORKERS' COMPENSATION	LIMITS
Workers' Compensation Coverage: Part One of the Coverage Document applies to the Workers' Compensation Law in the State of Texas.	
Each Accident	Statutory
Each Employee for Disease	Statutory
Employers' Liability Coverage: Part Two of the Coverage Document applies to the work in the State of Texas. The Limits of the Pool's Liability under Part Two are:	
Bodily Injury by Accident	$1,000,000 Each Accident
Bodily Injury by Disease	$1,000,000 Each Claimant
Aggregate per coverage period	$2,000,000
Optional Coverage	
Elected Officials	Yes
Volunteers - Fire Fighters	Yes
Volunteers - Law Enforcement	No
Volunteers - Emergency Medical Personnel	No
Volunteers - All Others	No
Jurors	No
Election Workers (non-employees)	Yes
WORKERS' COMPENSATION DEDUCTIBLE	
Deductible (per Occurrence)	**$0**
WORKERS' COMPENSATION ANNUAL CONTRIBUTION	**$62,639**

NOTICE OF ACCIDENT/CLAIM

Notice of an accident or claim (including service of process, if any) is to be delivered immediately to the Pool at:

Texas Association of Counties Risk Management Pool
Attention: WC CLAIMS
P.O. Box 160120
Austin, TX 78716
1-800-752-6301
Fax Number: 512-346-9321
Email: US-YORK-tacdwcforms@sedgwick.com

Any notice of claim and/or related documents should be mailed to the above immediately or by fax or email.

CONDITIONS

Coverage: This CCD is to outline limits, deductibles, and contributions only. All coverage is subject to the terms, conditions, definitions, exclusions, and sublimits described in the Coverage Documents, any endorsements, and the IPA.

Claims Reporting: The Named Member shall submit claims to the Pool as set forth in each applicable Coverage Document or as otherwise required by the Pool or state law.

Failure to Maintain Coverage: The Named Member's failure to maintain at least one coverage through the Pool will result in the automatic and immediate termination of the IPA.

Named Member Compliance: By executing the IPA, the Named Member agrees to comply with and abide by the Pool's Bylaws, applicable Coverage Documents, and the Pool's policies, as now in effect and as amended.

Payment of Annual Contribution: The Named Member shall pay contributions as outlined on invoices and as per the terms of the IPA.

Pool's Right to Audit: The Pool has the right, but no obligation, to audit and inspect the Named Member's operations and property at any time upon reasonable notice and during regular business hours, as the Pool deems necessary to protect the interest of the Pool.

Pool Coordinator: The Named Member shall appoint a Pool Coordinator. The name of the Pool Coordinator and the address for which notices may be given by the Pool shall be set forth in the space provided at the end of the IPA. The Pool Coordinator shall promptly provide the Pool with any required information.

The Named Member may change its Pool Coordinator and the address for notice by giving written notice to Pool of the change before the effective date of the change.

Any failure or omission of the Named Member's Pool Coordinator shall be deemed a failure or omission of the Named Member. The Pool is not required to contact any other individual regarding the Named Member's business except the named Pool Coordinator unless notice or contact to another individual is required by

applicable law. Any notice given by Pool or its contractor to the Pool Coordinator or such individual as is designated by law for a particular notice, shall be deemed notice to the Named Member.

Submission of Information: The Named Member shall timely submit to the Pool documentation necessary for the Pool to use to determine the risk to be covered for the next renewal period and to properly underwrite the risk exposure. The Pool will provide forms identifying the information requested.

Termination and Renewal: The coverage outlined in this CCD may be terminated or not renewed by either party as outlined in the IPA or applicable Coverage Document.

Termination for Failure to Pay: Notwithstanding any other provision in the IPA, if any payment or contribution for coverage owed by the Named Member to the Pool is not paid as required by the IPA, the Pool may cancel coverage or terminate coverage and the IPA, as the Pool deems appropriate, in accordance with the Pool's Bylaws and the applicable Coverage Document. The Named Member shall remain obligated for such unpaid contribution or charge for the period preceding termination.

This Contribution & Coverage Declaration is issued by  as authorized representative of the Pool on 11/08/2022 in Austin, Texas.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE ENDORSEMENT

This endorsement indicates that you have elected under this coverage document to provide workers' compensation health care services to your injured employees through the Political Subdivision Workers Compensation Alliance (Alliance).

The Pool will provide you with information concerning the use of the Alliance and your rights and responsibilities as a participant in this program. We will also provide you with information that may be given to your employees, including a notice of election to utilize the Alliance provider panel and an employee acknowledgement form.

ALL OTHER TERMS, CONDITIONS AND EXCLUSIONS OF THE COVERAGE REMAIN UNCHANGED.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

TEXAS VOLUNTEER WORKERS' COVERAGE AMENDATORY ENDORSEMENT

This endorsement provides coverage in addition to that provided under the Workers' Compensation and Employers' Liability coverage form for volunteers as listed below.

Schedule

Description of Risk	Estimated Payroll	Number of Employees
Volunteers - Fire Fighters	$5,618.00	1

ALL OTHER TERMS, CONDITIONS AND EXCLUSIONS OF THE COVERAGE REMAIN UNCHANGED.

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

IMPORTANT INFORMATION REGARDING ALLIANCE PARTICIPATION DO NOT DISCARD!

We are pleased that you have elected to utilize medical providers contracted by the Political Subdivision Workers' Compensation Alliance (Alliance) to treat your injured workers. We have enclosed all the information you will need in order to start using this program.

General Instructions for Employers

1. Employee Notification

As a participating employer, you are responsible for notifying your employees about the requirement to use health care providers that are under contract with the Alliance. This can be accomplished by providing your employees a copy of the **Employee Notice of Political Subdivision Workers Compensation Alliance (Alliance) Program Requirements**. Notice must be distributed to all employees and should be included in any new hire paperwork or during orientation.

2. Posting Notification

In addition to providing notice to each individual employee, a notice should be posted at each of your locations along with your current workers' compensation coverage notice, OIEC Notice and minimum wage posting.

3. Employee Signed Acknowledgement of Notice

i. Provide a copy or email the notice and acknowledgement form to all employees. You may distribute the notice and acknowledgement in a manner that is more electronically convenient, such as use of an intranet.
ii. Ask all employees to complete and return the acknowledgement form within a specific time frame (we recommend seven days).
iii. If the notice will be distributed at a scheduled staff meeting or safety meeting and the signed acknowledgement forms will also be collected, have witnesses available should any employee refuse to sign the form.
iv. New employees should receive the notice and return a signed acknowledgement as part of their "new hire" process.

Documentation

Establish a standardized process as indicated above for delivery of notice and acknowledgement form that includes documenting:

- The method of notice delivery
- To whom the notice was delivered
- The location of the delivery
- The date delivered

Please retain copies of the signed acknowledgement form(s) in each employee's personnel file. An employee who refuses to sign is still subject to direct contracting requirements. All refusals should be documented in the employee's personnel file. *Please do not return the signed forms to The Texas Association of Counties Risk Management Pool unless it is requested by an adjuster*.

What to Do When an Injury Occurs

If appropriate, provide or arrange transportation for the injured employee to a contracted Alliance provider or, if necessary, to the nearest emergency facility. As a reminder to the employee, you should provide the *Employee Notice of Political Subdivision Workers Compensation Alliance (Alliance) Program Requirements* (a copy is enclosed) to the injured employee at the time the injury is reported to you, or as soon as practical thereafter. The injured employee will need to sign the acknowledgement page. Please keep a copy of the signed form in your records. If necessary, your adjuster will request a copy from you.

Otherwise, you will continue with your usual procedure with regards to reporting work-related injuries. Remind the injured employee of the need to use Alliance providers and advise them how to locate a provider. You can search a list of the direct contract providers from the Alliance website at www.pswca.org. If you do not have access to the internet, please contact your adjuster at 800-752-6301 for a list of providers in your area.

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Employee Notice of
Alliance Program Requirements

Information, Instructions and your Rights and Obligations

As your employer, Tyler County has elected to utilize the Political Subdivision Workers Compensation Alliance (Alliance) to provide access to contracted physicians and healthcare providers for workers compensation injuries.

If you are injured at work, tell your supervisor or manager immediately. This information will help you seek care for your injury. Also, your employer will help with any questions about how to get treatment. TAC RMP and your employer have formed a team to provide you with timely care and treatment for work related injuries. The goal is to provide quality medical care and return you to work as soon as it is safe to do so.

Important Contact Information

Alliance
866-997-7922
www.pswca.org

TAC RMP WC Claims
P.O. Box 160120
Austin, TX 78716
800-752-6301

Injured Employees Rights and Obligations

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 Alliance treating physicians may be available from your employer. A complete list is also available online at www.pswca.org or you may contact your adjuster directly: TAC RMP WC Claims **800-752-6301**.

In case of an emergency

If you are hurt at work, you should first notify your employer and they will assist you in locating a provider or emergency care provider.

After you receive emergency care or treatment, you may require ongoing care. You will need to select a treating doctor from the Alliance provider list. This list is available at www.pswca.org. If you do not have internet access, please call **1-800-752-6301** or contact your employer for a complete listing. 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.

Choosing a Treating Doctor

If you are injured at work you must choose a treating doctor from the Alliance panel of providers. This is **REQUIRED** for the cost of your medical care for your work related injury to be covered. A provider listing is available through the Alliance website at www.pswca.org. It is updated weekly and identifies providers who are contracted with the Alliance and accept workers' compensation patients.

If your treating physician leaves the Alliance you will be notified and you will have the right to choose another treating doctor from the list of providers. If your doctor leaves the Alliance and you suffer a life threatening or acute condition for which a disruption of care would be harmful, your doctor will contact your adjuster to request that you treat with him/her for an additional 90 days.

Changing Doctors

If you become dissatisfied with your initial choice of treating physician, you can complete a *Change of Treating Doctor Form* to select a new treating doctor from the list of Alliance providers. This form is available by contacting TAC RMP WC Claims at **800-752-6301** and should be completed and submitted to your adjuster for approval ***prior*** to changing doctors.

Referrals

Referrals are not required for emergency care. Your treating doctor will refer you to other health care providers if necessary for your medical treatment.

Payments for Health Care

Alliance providers have agreed to bill TAC RMP for payment in relation to your health care. You should not be required to make payment at the time of your treatment. You may only access non-Alliance health care providers and remain eligible for coverage of your medical costs if one of the following situations occur:

- Emergency care is needed. You should go to the nearest hospital, urgent care, or emergency care facility
- You do not live within 75 miles of a contracted provider
- Your treating physician refers you to a non-Alliance provider or facility AND your adjuster has approved the referral prior to treatment.

Non-emergency care

Once you have selected your treating physician, your adjuster will be notified and they will contact you if additional information is required.

Complaints

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of the operation. This includes a complaint about the Alliance or an Alliance treating physician or facility. It may also be a general complaint about the Alliance - PSWCA Direct Contracting Program.

Complaints should be addressed to the Alliance - PSWCA Direct Contracting Program Grievance Coordinator by phone or in writing via email or fax. Complaints should be sent to:

PSWCA Direct Contracting Program
Attention: Grievance Coordinator
P.O. Box 203065
Austin, TX 78720-3065
1-866-997-7922
providerrelations@pswca.org

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Aviso al Empleado de los Requisitos del Programa de Alianza

Información, Instrucciones y sus Derechos y Obligaciones

Como su empleador, Tyler County ha elegido utilizar la Alianza Politica de Compensación de Trabajadoes de Subdivisión (Alliance) para proporcionar acceso a los médicos contratados y proveedores de atención médica por lesiones de compensación a los trabajadores.

Si usted se lesionado en el trabajo, dígale a su supervisor o gerente inmediatamente. Esta información le ayudará a buscar atención médica para su lesión. También, su empleador le ayudará con cualquier pregunta acerca de cómo obtener tratamiento. TACRMP y su empleador han formado un equipo para proporcionarle atención oportuna y tratamiento para lesiones relacionadas con el trabajo. El objetivo es brindar atención médica de calidad y volverlo al trabajo tan pronto como sea seguro hacerlo.

Información de Contacto Importante

Alliance
866-997-7922
www.pswca.org

TAC RMP WC Claims
P.O. Box 160120
Austin, TX 78716
800-752-6301

Derechos y Obligaciones para Empleados Heridos

Qué hacer si usted se lesiona en el trabajo:

Si usted se lesiona en el trabajo, avísele a su empleador tan pronto como sea posible. Una lista de medicos que participan en la Alianza puede ser disponible de su empleador. Una lista completa está disponible en el sitio web www.pswca.org o puede comunicarse con su ajustador directamente; TAC RMP Reclamos de compensacion de trabajadores 800-752-6301.

En caso de emergencia

Si usted se lastima en el trabajo, primero debe notificar a su empleador y le ayudarán a localizar un proveedor o proveedor de atención médica de emergencia.

Después de recibir tratamiento o atención de emergencia, puede que necesite atención continua. Debe seleccionar a un médico tratante de la lista de proveedores de la Alianza. Esta lista está disponible en el sitio web www.pswca.org. Si no tienes acceso al internet, por favor llame 1-800-752-6301 o comuníquese con su empleador para obtener una lista completa. El médico que elija se encargará de supervisar la atención que recibe por su lesión relacionada con el trabajo. Excepto para atención de emergencia, usted debe obtener todo el cuidado de la salud y especialista referidos a través de su médico de cabecera.

Elegir a un Medico Tratante

Si usted se lesiona en el trabajo debe elegir a un médico desde el panel de los proveedores de la Alianza. Esto es **NECESARIO** para que el costo de su atención médica por su lesion relacionada al trabajo sea cubierta. Una lista de proveedores está disponible a través de la página web de Alianza en www.pswca.org. Se actualiza semanalmente e identifica los proveedores que tienen contrato con la Alianza y aceptan a pacientes de compensación de trabajadores.

Si su médico tratante abandona la Alianza le notificaremos y usted tendrá el derecho a elegir a otro médico tratante de la lista de proveedores. Si su médico abandona la Alianza y su vida padece un peligro o tiene una condición aguda que una interrupción de la atención sería perjudicial, su médico se comunicará con su ajustador para solicitar seguir con él o ella por otros 90 días.

Cambiar Médicos

Si usted esta insatisfecho con su elección inicial de médico, usted puede completar la forma *Cambio de Médico* para seleccionar a un médico tratante nuevo de la lista de proveedores de la Alianza. Este formulario está disponible contactando al TAC RMP Reclamos al 800-752-6301 y debe ser completado y presentado a su ajustador para aprobación antes del cambio de medico.

Referencias
Referencias no son necesarias para la atención de emergencia. Su médico lo referira a otros proveedores de atención médica si es necesario para su tratamiento médico.

Pagos para el Cuidado de la Salud
Proveedores de la Alianza han accedido mandar bill de pago a TACRMP en relación con su atención médica. No se le deberia exigir pago en el momento de su tratamiento. Solo puede obtener un proveedor fuera de la Alianza y permanecer elegible para la cobertura de sus gastos médicos, por una de las siguientes situaciones:

- Se necesita atención de emergencia. Usted debe ir a la atención de urgencia, hospital o centro de atención de emergencia mas cerca
- Usted no vive dentro de 75 millas de un proveedor contratado
- Su médico tratante le envía a un proveedor o instalacion fuera de la Alianza y el ajustador ha aprobado la remisión antes del tratamiento

Cuidado no es de emergencia
Una vez que haya seleccionado a su médico tratante, su ajustador sera notificado y se comunicará con usted si se requiere información adicional.

Quejas
Usted tiene el derecho a presentar una queja con la Alianza. Puede hacer esto si usted está insatisfecho con cualquier aspecto de la operación. Esto incluye una queja acerca de la Alianza o un tratamiento médico o instalación de la Alianza. También puede hacer una queja general sobre el programa PSWCA Direct Contracting.

Las quejas deben dirigirse a la PSWCA Direct Contracting Program Grievance Coordinator por teléfono o por escrito al correo electrónico o fax. Los reclamos deben enviarse a:

PSWCA Direct Contracting Program
Atención: Grievance Coordinator (Coordinador de quejas)
P.O. Box 203065
Austin, TX 78720-3065
1-866-997-7922
providerrelations@pswca.org

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Employee Acknowledgement of Alliance Participation

I have received information that informs me of my employer's election to utilize the Political Subdivision Workers' Compensation Alliance (Alliance) and how to obtain health care if I should suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of contracted providers provided by my employer or obtain the list myself from www.pswca
2. I must go to my treating doctor for all health care related to my injury. If I need a specialist, my treating doctor will refer me. If I require emergency care I may go anywhere.
3. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.
4. Additional information regarding the Alliance is available on TAC RMP's website at www.county.org

_____

Signature Date

_____

Printed Name

I live at _____

Street Address

_____

City, State, Zip Code

_____

Name of Employer

Please indicate whether this is the:

__Initial Employee Notification

__Date of Injury Notification (date of injury ____/____/_____)

PLEASE RETURN THIS FORM TO YOUR EMPLOYER

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Reconocimiento del Empleado de Participacion en la Alianza

He recibido información que me informa de la elección de mi empleador a utilizar la alianza política de compensación de trabajadores de subdivisión (Alliance) y cómo obtener atención médica si sufro una lesion o enfermedad relacionada a mi trabajo.

Si yo me lesiono en el trabajo, entiendo:

1. Yo debo elegir a un médico tratante de la lista de proveedores contratados que ha sido proporcionado por mi empleador o obtener yo la lista de el sitio web www.pswca.org
2. Debo ir a mi medico tratante para toda atención médica relacionada con mi lesión. Si necesito a un especialista, mi medico tratante me referiré. Si necesito atención de emergencia puedo ir a cualquier lugar.
3. Falso reclamo o reclamo fradulento de compensación para trabajadores es un delito que puede resultar en multas y/o encarcelamiento.
4. Información adicional sobre la Alianza está disponible en el sitio web de TAC RMP en www.county.org

_____

Firma Fecha

_____

Imprimir Nombre

Yo vivo_____

Dirección de la calle

_____

Ciudad, Estado, Código postal

_____

Nombre del empleador

Porfavor indicar si se trata de la:

__ Notificación inicial al empleado

__ Fecha de la notificación de lesiones (fecha de la lesión ____/____/_____)

POR FAVOR DEVUELVA ESTE FORMULARIO A SU EMPLEADOR

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: Tyler County has workers' compensation insurance coverage from Texas Association of Counties Risk Management Pool in the event of work-related injury or occupational disease. This coverage is effective from 01/01/2023. Any injuries or occupational diseases which occur on or after that date will be handled by Texas Association of Counties Risk Management Pool. 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.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: Tyler County tiene cobertura de seguros de compensación para trabajadores con Texas Association of Counties Risk Management Pool para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde 01/01/2023. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por Texas Association of Counties Risk Management Pool. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation - TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

WORKERS' COMPENSATION and EMPLOYERS' LIABILITY
COVERAGE DOCUMENT

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

As authorized by Chapter 504 of the Texas Labor Code and pursuant to the provisions of Chapter 791 and Chapter 2259 of the Texas Government Code, the Texas Association of Counties Risk Management Pool (Pool) is a risk sharing arrangement among Texas County governments and other political subdivisions established as a group workers' compensation fund authorized to provide all compensation and Benefits required by the Workers' Compensation Law. This Coverage Document, offered as an alternative to a traditional insurance policy, describes the Benefits provided to members of the Pool pursuant to the Interlocal contracts between the Pool and its members. The Interlocal Participation Agreement (IPA) between member and the Pool is incorporated herein for all purposes.

The Contribution and Coverage Declarations (CCD) issued to the Named Member by the Pool is part of this Coverage Document, subject to the terms, conditions, definitions, exclusions, and sublimits contained in this Coverage Document, any endorsements, and the Interlocal Participation Agreement (IPA).

Words and phrases that are capitalized have special meaning. Refer to GENERAL DEFINITIONS.

Throughout this Coverage Document, 'you', 'your', 'yours', 'member' and 'Named Member' mean the governmental entity listed on the CCD Page with whom this contract is made. 'We', 'us', 'our', 'ours' and 'the Pool' refer to Texas Association of Counties Risk Management Pool (TAC RMP).

GENERAL DEFINITIONS

B. **Benefits** as used in Coverage Document means the Benefits payable for a Compensable Injury pursuant to the Workers' Compensation Law.

C. **Compensable Injury** means an injury that arises out of and in the course and scope of employment.

D. **Contribution** means the amount paid or payable by the Named Member to the Pool for this coverage.

E. **Contribution & Coverage Declarations (CCD)** means the document that sets forth the specific indication of the coverage, limits and deductibles, Contributions and special provisions elected by each Named Member, including any modifications made by issuance of any amendatory CCD or endorsement.

F. **Coverage Document** means this agreement between the Pool and Named Member, including any endorsements.

G. **Employee** means:
   1. a person in the service of a political subdivision who has been employed as provided by law; or

2. a person for whom optional coverage is provided under Sections 504.012 or 504.013 of the Texas Labor Code.

H. **Injury** means damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.

I. **Named Member** means the political subdivision within the State of Texas which is a current participant in the Pool and so designated in the CCD.

J. **Occurrence** means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

K. **Workers' Compensation Law** means the workers' compensation law as authorized by Chapter 504 of the Texas Labor Code.

GENERAL SECTION

A. THE COVERAGE DOCUMENT

This Coverage Document includes at its effective date the CCD and all endorsements and schedules listed there. It contains the terms of coverage afforded to you by virtue of your IPA with the Pool. The terms of this Coverage Document may not be changed or waived except by endorsement issued by us to be part of this Coverage Document.

B. WHO IS COVERED

You are covered if you are the Named Member listed in the CCD.

PART ONE
WORKERS' COMPENSATION COVERAGE

Where this Coverage Document conflicts with the Workers' Compensation Law, the Law controls.

A. HOW THIS COVERAGE APPLIES

This coverage applies to Injury by accident or Injury by disease. Injury includes resulting death.

1. Injury by accident must occur during the Coverage period.

2. Injury by disease must be caused or aggravated by the conditions of your employment. The Employee's last day of last exposure to the conditions causing or aggravating such Injury by disease must occur during the Coverage period and shall be considered the date of occurrence.

B. WE WILL PAY

We will pay promptly when due the Benefits provided by the Workers' Compensation Law for a Compensable Injury. If we make any payments in excess of the Benefits required by the Workers' Compensation Law on your behalf, you will reimburse us promptly.

C. WE WILL NOT PAY

Items precluded by statute in the Texas Labor Code.

D. WE WILL DEFEND

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for Benefits payable pursuant to this Coverage Document. We have the right to investigate and settle these claims, proceedings or suits and such settlement may be made without your consent. We have the right to make all final decisions concerning settlement of any claim, proceeding, or suit against you for Benefits payable herein, regardless of whether you must pay a deductible, self-insured retention, or other payment. If you settle a claim, proceeding or suit without our approval, it will be at your own expense.

We have no duty to defend a claim, proceeding or suit that is not covered by this Coverage Document.

E. OTHER COVERAGE

If other applicable coverage exists, we will not pay more than our share of Benefits and costs covered by both this Coverage Document and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance or self-insurance will be equal until the loss is paid.

F. RECOVERY FROM OTHERS

We have your rights, and the rights of persons entitled to the Benefits of this coverage, to recover our payments from anyone liable for the Injury. You will take reasonable and necessary actions to protect those rights for us and to help us enforce them.

PART TWO
EMPLOYERS' LIABILITY COVERAGE

A. HOW THIS COVERAGE APPLIES

This Employers' Liability Coverage applies to Injury by accident or disease.

1. **Injury** means damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.

2. The Injury must arise out of and be in the course and scope of the Employee's employment by you.

3. Injury as result of accident must occur during the coverage period.

4. Injury by disease must be caused or aggravated by the conditions of your employment. The Employee's last day of last exposure to the conditions causing or aggravating such Injury by disease must occur during the coverage period and shall be considered the date of occurrence.

5. If you are sued, the original suit and any related legal actions for damages must be brought in the United States of America, its territories or possessions.

B. WE WILL PAY

Subject to the limits stated in the CCD, we will pay all sums you legally must pay as damages because of the Injury of your Employees, provided the Injury is covered by this Employers' Liability Coverage.

C. EXCLUSIONS

This coverage does not cover:

1. Liability assumed under a contract;

2. Punitive or exemplary damages because of Injury to an Employee employed in violation of law;

3. Injury of an Employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your officers;

4. Any obligation imposed by a workers' compensation, occupational disease, unemployment compensation, or disability benefits law, or any

similar law;

5. Injury intentionally caused by you;

6. Injury occurring outside the United States of America, its territories or possession, and Canada. This exclusion does not apply to Injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;

7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any Employee, or any personnel practices, policies, acts or omissions;

8. Injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901-942), any other federal workers' or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. Injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an Employee due to Injury arising out of or in the course of employment, or any amendments to those laws;

10. Injury to a master or member of the crew of any vessel;

11. Fines or penalties imposed for violation of federal or state law;

12. Damages payable under the Migrant and Seasonal Agricultural Worker Protections Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder , and any amendments to those laws;

13. Damages arising out of operations for which you have violated or failed to comply with any Workers' Compensation Law;

14. Injury by disease unless written claim is made or suit is brought against you for loss because of Injury no later than thirty-six months after the coverage period set forth in the CCD.

D. WE WILL DEFEND

We have the right and duty to defend, at our expense, any claim, proceeding or

suit against you for damages payable by this Coverage Document. The Pool has the right to investigate and settle these claims, proceedings and suits and such settlement may be made without your consent. We have the right to make all final decisions concerning settlement of any claim, proceeding, or suit against you for Benefits payable herein, regardless of whether you must pay a deductible, self-insured retention, or other payment. If you settle a claim, proceeding or suit without our approval, it will be at your own expense.

The Pool has no duty to defend a claim, proceeding or suit that is not covered by this Coverage Document. The Pool has no duty to defend or continue defending after we have paid our applicable limit of liability under this Coverage Document.

E. LIMITS OF LIABILITY

Limits of liability are as shown on the CCD. We will not pay any claims for damages after we have paid the applicable limit of our liability under this Coverage Document.

F. RECOVERY FROM OTHERS.

We have your rights, and the rights of persons entitled to the Benefits of this coverage, to recover our payments from anyone liable for the Injury. You will take reasonable and necessary actions to protect those rights for us and to help us enforce them.

G. OTHER COVERAGE

If other applicable coverage exists, we will not pay more than our share of Benefits and costs covered by both this Coverage Document and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

H. ACTIONS AGAINST THE POOL

There will be no right of action against us under this Coverage Document unless:

1. You have complied with all the terms of this Coverage Document and the Interlocal Participation Agreement;

2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This coverage does not give anyone the right to add us as a defendant in an action against you to determine your liability.

PART THREE
NAMED MEMBER'S DUTIES IF INJURY OCCURS

Tell us at once if Injury occurs that may be covered by this Coverage Document. All of your duties apply to both Part One and Part two of this Coverage Document, and must be performed as a condition of coverage. Your other duties are listed here:

1. Provide for immediate medical and other services required by the Workers' Compensation Law.

2. Give us the names and addresses of the injured persons and of witnesses, and other information the Pool may need as provided by the Workers' Compensation Law.

3. Promptly give us all notices, demands and legal papers related to the Injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as the Pool may request, in the investigation, settlement or defense of any claim, proceeding or suit.

5. Do nothing after an Injury occurs that would interfere with our right to recover from others.

6. Do not voluntarily make payments, assume obligations or incur expenses, except at Named Member's own cost.

PART FOUR
CONDITIONS

A. AGREEMENT TO PARTICIPATE

Nothing in this Coverage Document supersedes or replaces the provisions of the Pool's Interlocal Participation Agreement that governs your right to participate in the Pool and states the conditions of your participation, including without limitation your duty to pay any deductibles authorized therein, to pay contributions, and to comply with actuarial and/or underwriting requirements unless said Interlocal Participation Agreement is amended by the TAC RMP Board of Trustees to provide so. The Pool's fulfillment of its obligations under this Coverage Document in accordance with the terms, conditions, definitions, limitations, and exclusions herein also fulfills any duty the Pool has under said Interlocal Participation Agreement to make workers' compensation or other coverage available to you and to pay claims related to such coverage.

B. INSPECTION

We have the right, but not obligation, to audit and inspect your operations and property at any time upon reasonable notice and during regular business hours, as we deem necessary to protect the interest of the Pool. We may give you reports on the conditions that we find. We may also recommend changes. While these recommendations may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your Employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards.

C. COOPERATION WITH RISK CONTROL PROGRAMS

We may provide risk control recommendations, training, consultations or other services to assist you in reducing losses. You shall cooperate with us to implement risk control programs for the purpose of eliminating or minimizing hazards that may contribute to losses.

D. COVERAGE PERIOD

The Coverage Period shall be the coverage period stated in the CCD.

E. TRANSFER OF YOUR RIGHTS AND DUTIES

Your rights and duties under this Coverage Document may not be transferred without our written consent.

F. CANCELLATION

1. If at any time this Coverage Document is cancelled by any party we hold any contributions which are refundable to you because they would have applied to the portion of the Coverage Document period that followed the effective cancellation date, we will return any such refundable contributions promptly at the end of the audit period during which the cancellation occurs.

2. If this Coverage Document, or any other coverage with the Pool, is cancelled prior to the expiration date, the contribution payable may be adjusted to reflect loss of package discounts, renewal credits or any other underwriting credits that are based upon participation in the Pool.

3. If this Coverage Document is cancelled before the end of the Coverage Document period, you may be subject to the short rate earned contribution factors.

G. POOL COORDINATOR

You are required to designate a representative, pursuant to Interlocal Participation Agreement, to make and receive communication with us.

H. THIRD PARTY ADMINISTRATOR

If we designate a Third Party Administrator (TPA), we retain all authority to control the defense and settlement of claims, suits, or proceedings otherwise covered by this Coverage Document, and we retain any duty to pay claims, damages, or expenses otherwise covered herein. We will give you notice of any such appointment which will include the address and phone number for the TPA. If a TPA is designated, you must timely provide to the TPA all notices and reports required by this Coverage Document including without limitation any legal papers, complaints, or demands related to 'Injury by accident' or Injury by disease' (which must be provided promptly) and any notices of the occurrence of such injuries. You must provide the TPA as soon as practicable with all information reasonably required to process and administer any claim, demand, or suit against you for which you seek coverage under this Coverage Document.