NOTICE TO EMPLOYEES

OF WORKERS' COMPENSATION INSURANCE FOR INDUSTRIAL INJURIES AND DISEASES

The undersigned, an employer subject to the provisions of the Workers' Compensation Act of Pennsylvania hereby gives notice to its employees and to all other persons interested, that it has secured the payment of the compensation payable to its employees and their dependents, by insuring with the **Old Republic Insurance Co.**

Claims and requests for information
are to be addressed to:

School Claims Services, LLC
Workers' Compensation Division
P.O. Box 813
New Cumberland, PA 17070

www.schoolclaimsservices.com
Phone: (866) 402-6600
Fax: (866) 402-6601

BUREAU CODE # **0027**

Expiration Date of Policy – July 1, 2017

REMEMBER – IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

PSBA InsuranceServices

SchoolClaims Services LLC

2015

Attention School Districts

Do not jeopardize your financial or legal rights.
Report all workers' compensation claims **immediately**.

The law requires wage loss claims be paid or denied
within **21 days of the date of disability**.
Failure to comply with the 21-day period could result in legal penalties.

As an Old Republic Insurance Co. Workers' Compensation
participant your claims are to be reported on-line at:

www.schoolclaimsservices.com

School Claims Services, LLC
Workers' Compensation Division
P.O. Box 813
New Cumberland, PA 17070
Toll-free Telephone: (866) 402-6600
FAX: (866) 402-6601

NOTICE TO EMPLOYEES
NORTHEASTERN ED IU # 19

chool Claims Service, LLC, Workers' Compensation Division, the claims administrator for the school district's orkers' compensation carrier, Old Republic Insurance Company, has required that we post the following list of ealth care providers in accordance with Section 306 of the Workers' Compensation Act. Please read the following otice carefully as it explains important rights and responsibilities.

IN CASE OF WORK-RELATED INJURY

If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and edical services and supplies, orthopedic appliances and prostheses, including training in their use, as and when eeded.

In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must elect from one of the licensed physicians or practitioners of the healing arts listed below.

DESIGNATED PHYSICIANS

MEDICAL PROVIDER	ADDRESS	PHONE	SPECIALTY
Mid-State Occupational Health Services, Inc. (Multiple Locations)	1000 Meade St. Medical Plaza Dunmore, PA 18512	570-209-7160	Occupational Medicine
Redi Care Medical Center (Multiple Locations)	648 North Main St. Taylor, PA 18517	570-348-1101	Occupational Medicine / Urgent Care
Orthopedic Consultants	909 SR 6 W Tunkhannock, PA 18657	570-288-3535	Orthopedics
Scranton Orthopedics	334 Main St. Dickson City, PA 18519	570-307-1767	Orthopedics
Casey Burke, DO Hand Surgery Assoc.	232 Sunrise Ave. Honesdale, PA 18431	570-877-2289	Orthopedics - Hand
Delta Medix	141 Salem Ave. Fl 2 Carbondale, PA 18407	570-282-1475	General Surgery
Professional Neurological Assoc. (Multiple Locations)	235 Main St. Suite 115 Dickson City, PA 18519	570-963-8803	Neurology
Northeastern Eye Institute (Multiple Locations)	503 South State St. Clarks Summit, PA 18411	570-587-5186	Ophthalmology
Allan Perfilio, DC Perfilio Chiropractic	614 Morgan Highway Clarks Summit, PA 18411	570-586-7778	Chiropractic
Steven Brown, DC Brown Chiropractic	1767 Quincy Ave. Dunmore, PA 18509	570-341-5544	Chiropractic
One Call Care Management (OCCM)	For locations and appointments, please call	800-453-0574	PT, DME, Diagnostic Studies, Home Health
Corvel	For prescriptions, please call	800-563-8438	Pharmacy

. You must continue to visit one of the persons listed, if you need treatment, for ninety (90) days from the date of your rst visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services endered during this period.

. After this ninety day period, if you still need treatment and your employer has provided a list as set forth above, you ıay choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your mployer of this action within five (5) days of your visit to the person of your choice. Failure to notify your employer will elieve the employer from liability for payment for services rendered prior to appropriate notice if the services are etermined to have been unreasonable or unnecessary.

. The physician or practitioner of the healing arts who treats you must file a report on a form provided by the Bureau of Vorkers' Compensation (Form LIBC-9) within ten (10) days of the commencement of treatment and at least once a ıonth as long as treatment continues. A copy of the report must be furnished to you and to your employer. The mployer is not liable for payment of any treatment until a report has been filed.

NOTICE TO EMPLOYEES
NORTHEASTERN ED IU # 19

School Claims Service, LLC, Workers' Compensation Division, the claims administrator for the school district's workers' compensation carrier, Old Republic Insurance Company, has required that we post the following list of health care providers in accordance with Section 306 of the Workers' Compensation Act.

IN CASE OF A WORK-RELATED INJURY

1. In order to ensure that your medical treatment will be paid for by your employer, or the insurance company, you must select from one of the licensed physicians or practitioners of the healing arts listed.
2. You must continue to visit one of the listed providers for ninety (90) days from the date of your first visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services rendered during this period.

DESIGNATED PHYSICIANS

See Reverse Side

You recognize and agree that your employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). You also acknowledge that you have been presented with this written notice setting forth your rights and duties under Section 306(f.1)(1)(I) of the Pennsylvania Workers' Compensation Act. Your rights and duties include the following:

1. I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for **ninety (90)** days from the date of first visit to a designated provider.
2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.
3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.
4. If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider.
5. I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period.
6. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services.
7. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.
8. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification; and
9. If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the treatment shall be performed by one or more of the designated health care providers for a period of ninety (90) days from the date of the visit to my health care provider (date of examination of the additional opinion).

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and understand my rights and duties.

_____ DATE

_____ EMPLOYEE'S SIGNATURE

_____ EMPLOYEE'S NAME (PLEASE PRINT)

_____ DATE

_____ WITNESS

Aug-16

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work related injuries, illness, or "near miss" events (which could have caused and injury or illness) – no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: ⑥ Injury ⑥ Illness ⑥ Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? ⑥ Yes ⑥ No	
Date of injury/near miss:	Time of injury/near miss:
Name of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? ⑥ Yes ⑥ No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? ⑥ Yes ⑥ No	
If yes, when?	Supervisor:
Your signature:	Date:

Supervisor's Accident Investigation Form

Name of Injured Person _____

Employee DOB _____ Employee SS Number_____

Employee Telephone Number _____

Employee Address _____

City _____ State _____ Zip_____

(Circle one) Male Female

What part of the body was injured? Describe in detail. _____

_____

What was the nature of the injury? Describe in detail. _____

_____

_____

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools were being used? _____

_____

_____

Names of all witnesses:

_____ _____

_____ _____

Date of Event _____ Time of Event _____

Exact location of event: _____

What caused the event? _____

_____

_____

Were safety regulations in place and used? If not, what was wrong? _____

_____

Employee went to doctor/hospital? Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

_____

_____

_____

_____ _____

Supervisor Signature Date

SchoolClaims Services LLC

Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:		Employer Address:			County:
Employee Name (last, first, initial):		Home Phone #:	Gender: M ☐ F ☐		Marital Status: M ☐ S ☐ Dep.:
Home Address (street, city, state, zip code):					County:
Social Security #:	Date of Birth:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:
Location of Incident (building, room, etc.):			Type of Injury (cut, sprain, etc.):		
Injured Body Part:			Cause of Injury (machine, tool, equipment, liquid, etc.):		
Employee's Job Title:	Hours Worked Per Week:		Name of Witness(es):		

Description of Incident (please describe in detail what happened):

Employee Name:	Employee Signature:	Date:
Employee's Supervisor Name:	Employee's Supervisor's Signature:	Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: _____ ☐ New ☐ Other (describe): _____

Treatment/First Aid: _____

Diagnosis: _____

Disposition: _____

☐ Return to work without limitations

☐ Return to work with limitations (describe): _____

☐ May return to work on: _____

☐ Follow-up appointment with: _____ on _____

Signature of medical/first aid provider _____ **Date:** _____

Medical Facility Address:

What to do if You Are Injured at Work?

As soon as practicable, report the incident to your Supervisor, Human Resources, or your employer's Worker's Compensation Coordinator so they can report it to our office, even if you don't think you need medical treatment.

- Make sure your employer has your most up-to-date contact information, including phone numbers, home address, and personal email.

Your employer will file your claim electronically with School Claims Services, who will assign an Injury Manager to work with you going forward.

- If you require medical treatment, your employer will give you a copy of your Injury Report that will include your confirmation/claim number. To avoid delays, take the Injury Report with you to your initial doctor's appointment.
- When seeking medical attention on for a work-related injury occurring after hours, tell the medical provider that yours is a Workers' Compensation injury. Remember to report the incident to your employer the next business day.

Your employer should give you a copy of your Provider Panel.

- A Provider Panel is a list of medical providers you must with the first 90 days following a work-related injury. You must sign a form acknowledging your receipt of the Provider Panel information.

****PLEASE NOTE****

If immediate emergency care is needed, go to the nearest emergency room for the initial visit. Follow-up visits should then be scheduled with a medical provider on the Provider Panel.

Write down questions you may have for your medical provider and take them with you on your first visit.

- Communicate any concerns about your treatment to your medical provider and to your School Claims Service Injury Manager.

Continued...

The following services should be scheduled through the providers listed below during the first 90 days of a claim.

- MRI, CT, EMG – One Call Medical (800-453-0574)
- Physical Therapy – Alignetwork (866-389-0211)
- Prescriptions – Corvel (800-563-8438)

A Model of Care and Concern — How We Can All Work Together

- You can expect contact from your Injury Manager between 8 a.m. and 5 p.m. to discuss your injury and if applicable, a treatment strategy.
- Watch your mail for paperwork that will need to be filled out immediately and returned to our office or given to your medical provider. A self-addressed stamped envelope will be included for your use for the materials that are to be sent back to School Claims Services.
- A pharmacy card will be issued to you once your claim has been accepted and Workers' Compensation benefits are approved. This card is to be used for all prescription purchases as prescribed by your medical provider.
- Call your Injury Manager after every doctor appointment to relay the most current medical and return- to- work information.

School Claims Services wants to help get you back to your pre-accident condition as quickly as possible.

If you have any questions or concerns, please do not hesitate to call our office: 866-402-6600

PROVIDER PANEL: Information and questions

- The significance of a physician panel list is multifaceted. From an expense standpoint, the listing will assist in direction of care to the most appropriate provider for the injury (i.e.: Injured Worker can be evaluated and treated at the designated occupational health clinic versus the local emergency room, for non-emergent injuries, thus resulting in an estimated minimum savings of $2,000).
- Posted physician panels account for an average of 48.2 lost days versus 63.3 lost days with no posted panel (Medical Access Study Executive Overview).
- Physician panels are required to have a minimum of six providers (including at least three physicians and no more than four coordinated care organizations.
- The school district cannot direct treatment with any one specific provider on the list nor can they restrict the Injured Worker from switching from one designated provider to another. You must advise your Injury Manager if you switch from one provider to another.
- Annual review of your physician panel is strongly encouraged (are the providers on your panel still in practice, have they relocated, are they aware of your district's Return-to-Work and/or transitional duty program, if applicable, etc.)
- Does your current panel include specialties that are needed for your Injured Workers? (ie: has your district experienced eye injuries, thus needing an ophthalmologist; dental injuries, thus the need for a dentist, etc.)
- Have your employees signed the "Notice of Employee Rights and Duties"? *(see pages 8-9 for the form)*

★ As a PSBA Insurance Trust Workers' Compensation participant, you have a direct line to valuable resources through the Workers' Compensation Claims Division at School Claims Services.

★ Your panels can be assessed ***free of charge*** and options can be discussed on improving the make-up of your current panel.

★ Your panel is a primary tool against excessive claim dollars, which can relate directly to your Experience Modification factor development, which can in turn directly affect your Workers' Compensation premium calculation.

★ The time that it will take to review and update your panel is well worth the improved relationships with your Injured Worker(s), as well as the money that the district could save in expense dollars.

We look forward to assisting you in controlling your Workers' Compensation Claims Costs.

Christine M. Curtis, RN, BSW, CCM
School Claims Services, LLC
Manager of Medical Services
866-402-6600 x7244; fax: 866-402-6601; email: ccurtis@schoolinsco.com

RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.