

September 21, 2021

Robert Morris University
Moon Twp, PA 15108

Dear Valued Workpartners Policy Holder,

Thank you for choosing Workpartners for your workers' compensation program. As part of our services, we have enclosed your workers' compensation provider panels developed for your workplace locations to be utilized for work-related injuries sustained from your policy effective date and going forward. In the event of a panel update, that updated listing will be effective as of the date of notice and is to be used for any work-related losses reported from that day forward.

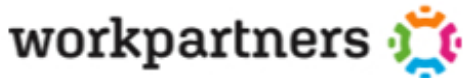
Posting of an up-to-date workers' compensation panel is a requirement under the Pennsylvania Workers' Compensation Act. You are also required to have your employees sign the Employee Rights and Duties Form, which confirms they are aware of your designated Workers' Compensation Provider Panel. This signature is required at time of hire/establishment of new panel and after an injury is reported. For your convenience, we have attached a copy of the Employees Rights and Duties and Employee Acknowledgement forms.

Please confirm your receipt and agreement to post the attached workers' compensation panels at your designated workplace location(s). In order that a panel is available for your employees as quickly as possible, we look forward to hearing your feedback within five (5) calendar days. After that time period we will accept the panel as approved by you, in the absence of a response.

If you have any questions or requests regarding your panel creation, please contact WCPanels@upmc.edu. We appreciate the opportunity to partner with you.

Sincerely,

Workpartners Panel Management Team



Robert Morris University - Moon Twp (15108)
 YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
 Send Bills To: PO Box 2971, Pittsburgh, PA 15230
 Fax: (412) 454-8717
 To Report a Claim Call: 1-800-633-1197
 WC Policy:WC100-0007675
 Policy Effective Date:07/01/2021

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
*Concentra Medical Center - Robinson All Locations - Concentra.com	4390 Campbells Run Rd Pittsburgh, PA 15205	412-429-9675	Occupational Medicine
*Concentra Medical Center - West End All Locations - Concentra.com	1600 W Carson St, Ste 200 Pittsburgh, PA 15219	412-391-1137	Occupational Medicine
MedExpress Urgent Care - Moon Township All Locations - MedExpress.com	8702 University Blvd Moon Township, PA 15108	412-299-3627	Urgent Care
Surgical Associates of Sewickley	111 Hazel Ln, Ste 100 Sewickley, PA 15143	412-741-8862	General Surgery
*UPP Dept of Neurosurgery - UPMC Presbyterian	200 Lothrop St, Ste B400 Pittsburgh, PA 15213	412-647-3685	Neurosurgery
*Tri Rivers Musculoskeletal Centers - North Hills	9104 Babcock Blvd, Ste 2120 Pittsburgh, PA 15237	866-874-7483	Orthopedics
*UPP Dept of Orthopaedic Surgery - UPMC Shadyside	5200 Centre Ave, Ste 415 Shadyside Medical Building Pittsburgh, PA 15232	412-858-0385	Orthopedics
Sewickley Eye Group - Sewickley	400 Broad St, Ste 2020 Sewickley, PA 15143	412-741-4610	Ophthalmology
Dr Brian M Ernstoff MD - Robinson Plaza	3 Robinson Plaza, Ste 440 Pittsburgh, PA 15205	412-901-2891	Physiatry (Musculoskeletal Injuries)
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME

*In accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.



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<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

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WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

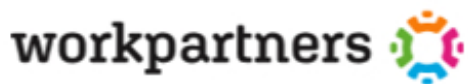
For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)

certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.



EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

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

Employee's Signature Date

Employee's Name (Print) Employee Number

Employer Department

Witness' Signature Date

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