Keep this page for your records.

PENNRIDGE SCHOOL DISTRICT

DISTRICT ADMINISTRATION OFFICE
1200 North Fifth Street ● Perkasie, Pennsylvania 18944

Tara Mossman; Director, Human Resources

TO: INJURED EMPLOYEE
RE: Worker's Compensation

On behalf of the District, please accept our condolences for your job-related injury. We wish to make every effort to assist you in receiving the proper medical treatment so that you have a speedy recovery from the injury.

TO REPORT YOUR CLAIM:
Please call 1-800-445-6965
Or
online at sdicwc.org (click "Report a Claim" button).

The following forms (attached) are required for your information and/or to complete. Please hand everything in to your building principal so they can be returned to Donna Schepis in the **Human Resources** department as soon as possible in order for your claim to be processed in a timely fashion.

The Supervisor Incident Report needs to be completed and signed by you and your supervisor. (return to HR)

These documents are required whether or not you seek medical treatment.

1. **What to do in case of a work-related injury.** Please complete this form by **signing the second page**. This indicates you understand the process and are in receipt of the panel of eligible physicians. (return to HR)
2. **Rights and Duties Form.** Employee acknowledgement letter explains employee rights under the Workers' Compensation Act. **Sign bottom and have a witness (to your signature) also sign**. (return to HR)
3. **Workers' Compensation Report.** Please complete form with as much information as possible. Make sure your supervisor and any witnesses also **sign where indicated**. (return to HR)
4. **SDIC Worker's Compensation Medical Information Release and Employment Record Release. Please complete the bottom of this form and sign**. This form allows SDIC (our worker's compensation insurer) to receive information related to your injury from treating physicians. (return to HR)
5. **MITCHELL ScriptAdvisor.** This form is your temporary prescription card. If your treating physician prescribes medication for your work related injury, this document explains how prescriptions are filled. (yours to keep)
6. **Workers Compensation & the Injured Worker**. This brochure is a general information guide for injured workers on the Pennsylvania Workers' Compensation Act for work injuries and illnesses occurring on or after June 24, 1996. (yours to keep)
7. **Election of Compensation form.** This form is to ensure that you receive your preferred method of compensation **if you have lost any time from work (or should you lose time in the future)**. Please complete in the event that your injury disallows you from working. (return to HR)

TM/dls
Attachments

Keep this page for your records.

<u>These documents are required when you do not seek medical treatment</u>. If you choose not to seek medical treatment the following document must also be completed.

1. **Medical Treatment Waiver Form**. This form should be completed if you do not intend to seek medical treatment. This does not need to be completed if you are seeking medical treatment. **Please complete the bottom of this form and sign**; **Have a witness sign to attest to you signing the form.** (return to HR)

YOU SHOULD NOT PAY ANY BILLS OR CHARGE ANY COSTS TO YOUR HEALTH INSURANCE COMPANY!

If this injury requires any absence from work, it will be necessary for you to obtain a statement from your physician specifying the extent of the injury and the expected (or actual) date of return to work.

It is important to keep Human Resources, as well as your supervisor, updated on the status of your injury and the length of your absence. You are also responsible for entering any absences in Kronos or AESOP until other arrangements are made with your supervisor and/or Human Resources.

Please be aware that if you are out of work and being compensated by our worker's compensation company, you will be responsible for payment of current bi-weekly health/dental insurance co-pays if they are deducted from your paycheck. Human Resources will bill you for these charges until you return to work.

You will also be responsible for payment of your PSERS contribution to receive years of service credit for this time off. To take care of this benefit, please contact the payroll department at 215-453-2721.

Please contact Donna Schepis in the Human Resources at 215-453-2368 upon your return to work and/or if you have any questions regarding your injury and/or this process.

You have our best wishes for a full and speedy recovery.

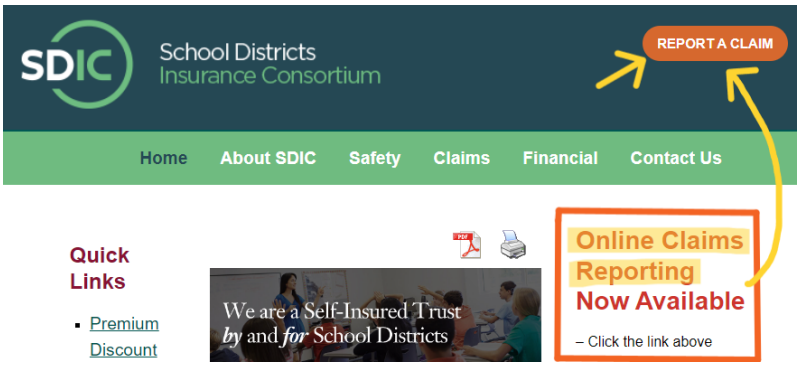
Keep this page for your records.

INSTRUCTIONS FOR EMPLOYEE

WORKERS' COMPENSATION CLAIMS REPORTING

Please read the entire contents of the packet and follow directions below.

1. Report your work-related claim ***as soon as possible*** by phone at **1-800-445-6965** or online at **sdicwc.org** (click the "Report a Claim" button).



2. Advise your School District Workers' Compensation Coordinator that you have reported your work-related claim.

3. You must seek medical treatment for your claimed injury with one of the providers listed on your **POSTED PANEL** for ninety (90) days from the date of your first visit.

4. Please provide your claim number and SDIC's address below to all medical providers. *Do NOT use your District medical benefits for WC claims.*

5. Please use the enclosed temporary Pharmacy Card and Pharmacy Sheet. Prescriptions may be filled at your local Walgreen's, CVS Pharmacy, Rite Aid, Walmart, Safeway, or Target. Mitchell International, our pharmacy benefit manager, will send you a personalized pharmacy benefit card for future prescriptions. **Mitchell Script Advisor** can be reached at: 1-866-846-9279. *Do NOT use your District prescription benefit card for WC claims.*

6. Please complete the enclosed documents as promptly as possible.

7. Please notify your **Claims Representative at SDIC** and your **Workers' Compensation Coordinator** immediately when you receive a **return-to-work date.**

Please call **1-800-445-6965** if you need any assistance or have questions regarding your work-related injury.

School Districts Insurance Consortium
P.O. Box 1249
North Wales, PA 19454
1-800-445-6965

SDIC School Districts Insurance Consortium

Pennridge School District

Effective Date: July 1, 2024 – June 30, 2025

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 and necessary surgical and medical services and supplies, orthopedic appliances and prosthesis, including training for their use. First, you MUST report the injury to your supervisor who will provide you with an SDIC claim reporting packet. Please contact your district Workers Compensation Coordinator:

   Donna Schepis - Confidential Secretary 215-453-2368

2. Next, please call SDIC @ (800) 445-6965 or report your claim online at www.sdicwc.org (click the "Report a Claim" button). When you call SDIC with your report of injury, you will be assigned a claim number for use when seeing a panel physician. Please contact your designated claims adjuster for all inquiries.
3. To ensure that reasonable and necessary medical treatment will be paid by your employer or the insurance company, you ***must*** treat with one of the health care providers listed in the panel below for the first ninety (90) days from the date of first treatment.
4. If a panel provider below refers you to another licensed specialist, your employer or their insurer will pay for the reasonable and necessary services.
5. If you still need treatment after the initial ninety (90) day period, and your employer has provided the list as set forth below, you may choose to go to another health care provider for treatment. You must notify your employer of this action within five (5) days of your visit to said provider.
6. If a panel physician prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's 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 listed panel physicians for the first ninety (90) 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 panel provider listed below.
8. The Commonwealth has no direct jurisdiction over out of state providers under PA Workers' Compensation Act. Treatment with out of state providers may result in you being billed for excess amounts over the PA Act 44 Fee Schedule. Your insurance company is not responsible for any fees over and above the fee schedule. If you prefer to seek treatment with an out of state provider, you should discuss this possibility with your provider prior to initiating treatment.
9. If you require a prescription for your work-related injury or disease, **do not use your personal health plan prescription card**. Please use the Mitchell International First Fill sheet provided in the claim package.

Name	Address	Scheduling	Area of Specialty
Grand View's Workplace Health and Wellness	4 Lifemark Dr Sellersville, PA 18960	215-453-4941	Occupational Medicine
Concentra Medical Centers	850 Germantown Pike Plymouth Meeting, PA 19462	610-275-3884	Occupational Medicine
Patient First	713 Bethlehem Pike Montgomeryville, PA 18936	267-695-3944	Urgent Care
Grand View Urgent Care at Quakertown	5 Quakers Way Quakertown, PA 18951	215-453-5620	Urgent Care
St. Luke's Upper Bucks Family Medical Center	200 Apple Street Suite 2 Quakertown, PA 18951	215-529-5210	Family Practice
Quakertown Family Medical Center	920 Lawn Avenue Suite 4 Sellersville, PA 18960	267-347-4747	Family Practice
Upper Bucks Orthopaedic at Grand View Health	915 Lawn Ave Sellersville Outpatient Ctr Sellersville, PA 18960	215-257-3700	Orthopedics
Rothman Orthopaedics	1200 Manor Dr Chalfont, PA 18914	367-339-3776	Orthopedics
St. Luke's Orthopedics Care	1534 Park Ave Ste 210 Quakertown, PA 18951	484-526-1735	Orthopedics
Grand View Health Surgery	915 Lawn Ave Ste 203 Sellersville, PA 18960	215-453-3400	General Surgery
Matossian Eye Associates	501 Hyde Park Doylestown, PA 18902	215-230-9200	Ophthalmology
Eye Care of the Valley	127 S 5th St Ste 200 Quakertown, PA 18951	215-538-3888	Ophthalmology
Penn Neurology	920 Lawn Avenue Suite 5 Sellersville, PA 18960	215-257-4900	Neurology

Claimants may use nearest or any location for all providers listed above.

One Call®PT Network	Call Toll Free for Closest Location	1-855-629-6226	Physical Therapy
NovaCare Rehabilitation	Call Toll Free for Closest Location	1-866-723-NOVA	Physical Therapy
One Call®Chiropractic Network	Call Toll Free for Closest Location	1-855-629-6226	Chiropractic
One Call®Diagnostic Network	Call Toll Free for Closest Location	1-855-629-6226	Diagnostics
One Call®DME/Home Health Network	Call Toll Free for Closest Location	1-855-629-6226	DME/Home Health
One Call®Dental Network	Call Toll Free for Closest Location	1-855-629-6226	Dental

Prepared for you by One Call

2024-2025

All workers' compensation claims will be processed on behalf of the School District by:

SCHOOL DISTRICTS INSURANCE CONSORTIUM

P.O. BOX 1249 NORTH WALES, PA 19454

Phone: (800) 445-6965

ACKNOWLEDGMENT: I have been informed of and understand my rights and duties as specified herein.

Signature: _____ Date: _____

Please Print Name: _____

*At time of distribution, this information is accurate to the best of our knowledge. This panel is subject to change based on information received from the medical provider.

Please return this completed form to your district Workers' Compensation Coordinator.

SDIC School Districts Insurance Consortium

Pennridge School District

Fechas Efectivas: July 1, 2024 – June 30, 2025

AVISO A LOS EMPLEADOS EN CASO DE LESIONES RELACIONADA AL TRABAJO

1. Si usted sufre una lesión relacionada al trabajo, su empleador o su compañía de seguros debe pagar por servicios y suministros quirúrgicos y médicos razonables y necesarios, aparatos ortopédicos, y prótesis, incluyendo entrenamiento para su uso. Primero, usted TIENE que reportar la lesión a u supervisor quien le proporcionara un paquete de reportar reclamos de SDIC. Por favor comuníquese con su coordinador de compensación para Trabajadores de su distrito:

Donna Schepis - Confidential Secretary 215-453-2368

2. Próximo, llame SDIC al (800) 445-6965 o reporte su reclamo en línea al www.sdiwc.org (haga clic al botón “Reporte un Reclamo”). Cuando llame a SDIC con su reporte de lesión, va a ser asignado un numero de reclamo para uso cuando vea a un medico del panel. Comuníquese con su ajustador de reclamos designado para todas las consultas.

3. Para asegurar que sea pagado su tratamiento razonable y necesario por su empleador o compañía de seguros, usted *tiene* que tratar con uno de los proveedores médicos en la lista del panel a continuación por noventa (90) días a partir de la fecha del primer tratamiento.

4. Si un proveedor del panel a continuación le refiere a otro especialista licenciado, su empleador o su aseguradora pagaran por servicios razonables y necesarios.
5. Si aún necesita tratamiento después del período inicial de noventa (90) días, y su empleador le ha proporcionado la lista que se establece a continuación, puede acudir a otro proveedor de atención médica para recibir tratamiento. Tiene que notificar a su empleador de esta acción dentro de los cinco (5) días de su visita a dicho proveedor.
6. Si un médico del panel prescribe una cirugía invasiva, puede obtener una segunda opinión de cualquier médico de su elección. Si la segunda opinión es diferente a la opinión del médico mencionado, usted puede determinar qué curso de tratamiento seguir; sin embargo, la segunda opinión debe contener un plan de tratamiento específico y detallado. Si elige la segunda opinión, los procedimientos en esa opinión deben ser realizados por uno de los médicos del panel enumerados durante los primeros noventa (90) días.
7. Si se enfrenta con una emergencia médica, puede obtener asistencia de un hospital, medico, o proveedor de atención medica de su elección para su lesión relacionada al trabajo. Sin embargo, cuando se resuelva la emergencia, debe buscar tratamiento de un proveedor del panel a continuación.
8. El Estado Libre Asociado no tiene jurisdicción directa sobre proveedores fuera del estado bajo la Ley de Compensación para Trabajadores de Pennsylvania. Tratamiento con proveedores fuera del estado puede resultar en que les facturen cantidades en exceso sobre la agenda de tarifas de la Ley 44 de Pennsylvania. Su compañía de seguros no es responsable de ningún cobro sobre la agenda de tarifas. Si prefiere buscar tratamiento con un proveedor fuera de estado, debe analizar esta posibilidad con su proveedor antes de iniciar tratamiento.
9. Si usted requiere una receta por su lesión o enfermedad relacionada al trabajo, **no use la tarjeta de receta de salud medica personal**. Por favor utilice la hoja de Mitchell International First Fill incluida en el paquete de reclamo.

Name	Address	Scheduling	Area of Specialty
Grand View's Workplace Health and Wellness	4 Lifemark Dr Sellersville, PA 18960	215-453-4941	Occupational Medicine
Concentra Medical Centers	850 Germantown Pike Plymouth Meeting, PA 19462	610-275-3884	Occupational Medicine
Patient First	713 Bethlehem Pike Montgomeryville, PA 18936	267-695-3944	Urgent Care
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Penn Neurology	920 Lawn Avenue Suite 5 Sellersville, PA 18960	215-257-4900	Neurology

Los reclamantes pueden usar la ubicación más cercana o cualquier ubicación para todos los proveedores mencionados anteriormente.

One Call®PT Network	Call Toll Free for Closest Location	1-855-629-6226	Physical Therapy
NovaCare Rehabilitation	Call Toll Free for Closest Location	1-866-723-NOVA	Physical Therapy
One Call®Chiropractic Network	Call Toll Free for Closest Location	1-855-629-6226	Chiropractic
One Call®Diagnostic Network	Call Toll Free for Closest Location	1-855-629-6226	Diagnostics
One Call®DME/Home Health Network	Call Toll Free for Closest Location	1-855-629-6226	DME/Home Health
One Call®Dental Network	Call Toll Free for Closest Location	1-855-629-6226	Dental

Prepared for you by One Call

2024-2025

Todos los reclamos de compensación para trabajadores serán procesados de parte del Distrito Escolar por:

SCHOOL DISTRICTS INSURANCE CONSORTIUM

P.O. BOX 1249

NORTH WALES, PA 19454

Teléfono: (800) 445-6965

RECONOCIMIENTO: He sido informado y entiendo mis derechos y deberes como se especifican en este documento.

Firma:_____ Fecha:_____

Nombre en Letra Imprenta:_____

*Al momento de distribución, esta información es correcta al mejor de nuestro conocimiento. Este panel está sujeto a cambios según la información recibida de proveedor médico.

Por Favor regrese este formulario llenado a su Coordinador de Compensación para Trabajadores de su distrito.

Sign & Date this page; Have a witness (to your signature) sign & date this page; Retain a copy for your records. Return original to HR.

EMPLOYEE'S RIGHTS AND DUTIES
UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT SECTION 306(F.1)

If you are injured while at work and need medical treatment, you are required to visit one of the health care providers on the list designated by your employer. This duty continues for 90 days from the date of your first visit with a provider on that list, or from the date of any emergency treatment, whichever is earlier.

All reasonable and necessary medical treatment and supplies (such as medicines and prosthetics) that you need as a result of the injury will be paid for by the employer if the treatment is prescribed by a designated health care provider during the 90-day period. Charges for treatment and supplies are specified by the Workers' Compensation Act. You are not responsible for paying any charges that exceed those specified by the Act.

During the 90-day period, you may change from one designated health care provider to another provider **on the list**, and the treatment will be paid for by the employer.

If the designated health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider. However, any subsequent non-emergency treatment must be provided by a designated health care provider for the remainder of the 90-day period.

If a designated health care provider recommends invasive surgery, you may obtain a second opinion from a health care provider of your choice. Your employer will pay for the cost of this opinion. If this opinion differs from the opinion of the designated health care provider and sets out a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment, however, must be provided by a designated health care provider for 90 days from the date of the visit to the non-designated health care provider.

After the 90-day period has ended, you have the right to seek treatment from any physician or health care provider. Your employer will pay for this treatment if it is reasonable, necessary, and related to your work injury. However, you must notify your employer of treatment by a non- designated health care provider within 5 days of your first visit to this provider. Your employer is not required to pay for treatment by a non-designated health care provider before you give this notice. Once you have given this notice, your employer shall pay for this treatment unless the treatment is found to be unreasonable or unnecessary, or unrelated to your work injury.

By signing this form, you acknowledge your rights and duties. You may not refuse to sign this form in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers' Compensation at 1-800-482-2383 or (717) 783-5421.

I acknowledge that I have been informed of and understand the above rights and duties.

_____ _____

Employee Signature Date

_____ _____

Employer's Representative Signature Date

Sign & date this page; Have a supervisor & witness attest (& sign) to the incident when applicable. Retain a copy for your Records. Return Original to HR.

WORKERS' COMPENSATION REPORT
EMPLOYEE/SUPERVISOR/WITNESS

Note to Employee: All areas of this report must be completed. Otherwise, it will be returned to you and delay the processing of your claim.

If you are unable to return to work because of your injury, you MUST contact Human Resources by the following business day. Failure to do so could jeopardize your claim.

Name	Soc. Sec. #	Date of Accident	Date of Hire	Date of Birth

Address:

Number Street Apt.# City State Zip Code

Phone Number (Include area code)	**Accident Reported to:** **Title:**
Building where Injured: **School District:** **Contact: _____**	**Other Employer(s):** **Address:** **Position:**

Describe Accident/Injury:

Have you returned to work? (circle one) YES NO If YES, when?

Date of first treatment: _____ **Are you still under treatment? (circle one) YES NO** **Medical treatment was received from: _____**	**List prior injuries or conditions:**

Employee Signature: Date:

WITNESS' REPORT
Witness Name: (Please Print)
To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one) YES NO
If you are unable to confirm the claimant's version of the accident, please explain why:

Witness' Signature: Date:

SUPERVISOR'S REPORT
Supervisor's Name: (Please Print) _____
This employee reported the above incident to me on:
To the best of my knowledge, this accident occurred as reported by the claimant. (Circle one) YES NO

If you are unable to confirm the claimant's version of the accident, please explain why:

List recommendations to prevent recurrence:

Supervisor's Signature: Date:

Sign & date this page; You will receive a claim number when you call to report your claim to SDIC. Retain a copy for your Records. Return Original to HR.

SDIC Workers' Compensation Medical Information Release and Employment Record Release

EMPLOYER #: _____ CLAIM #: _____

EMPLOYEE'S NAME: _____

EMPLOYEE'S SOCIAL SECURITY NUMBER: _____

NAME OF SCHOOL DISTRICT: Pennridge School District

Dear Medical Services Provider/Employer:

By signing below, I hereby authorize you to disclose to SDIC (School Districts Insurance Consortium), or its representatives, any and all information that you may have regarding my condition while under your treatment at any time. This authorization specifically includes my medical history findings, consultations, prescriptions, treatments, x-rays, special consultation reports, diagnosis, prognosis and copies of all hospital records and/or medical records from whatever source. This release also includes employment records, records from the Bureau of Workers' Compensation and prior accident records.

A photostatic copy of this Medical Release shall be considered as effective and valid as the original.

Written authorization shall remain valid for the duration of this claim unless consent is withdrawn in writing.

Employee's Signature: _____ Date: _____

Home Address: _____

_____

_____

Employee's Home Telephone Number: ( ) _____

School Districts Insurance Consortium
P.O. Box 1249
North Wales, PA 19454
1-800-445-6965

MyMatrixx
By EVERNORTH

SDIC

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: 773A

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this Workers' Compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30 day supply or a cost of $300. This form is valid for up to 15 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number 773A
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDI-CAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

WORKERS' COMPENSATION AND THE INJURED WORKER

www.dli.pa.gov

This brochure is a general guide for injured workers on the Pennsylvania Workers' Compensation Act for work injuries and illnesses occurring on or after June 24, 1996. This is general information only and does not represent official interpretations of the law. Injured workers are encouraged to discuss questions and concerns regarding the workers' compensation law and the additional options with legal counsel.

What is workers' compensation?

If you sustain a job injury or a work-related illness, the Pennsylvania Workers' Compensation Act, or Act provides payment for your medical expenses and, in the event you are unable to work, wage-loss compensation benefits until you're able to go back to work. Additionally, death benefits for work-related deaths are paid to your dependent survivors.

Benefits are paid by private insurance companies (also includes third-party administrators) or the State Workers' Insurance Fund (a state-run workers' compensation insurance carrier) or by self-insured employers.

Are you covered?

Nearly every Pennsylvania worker is covered by the Act. Employers must provide workers' compensation coverage for all of their employees, including seasonal and part-time workers. Nonprofit corporations, unincorporated businesses and even employers with only one employee must comply with the Act's requirements.

Some employees are covered by other compensation laws, including federal civilian employees, railroad workers, longshoremen, shipyard and harbor workers. Others who may not be covered include volunteer workers, agricultural laborers, casual employees, domestics and employees who have been granted a personal religious exemption from the Act. Certain types of executive officers of corporations may elect exemption from the Act. A worker should seek further information if there is any doubt as to coverage.

If you learn that your employer does not have insurance or is not self-insured for workers' compensation, you may be eligible for benefits from the Uninsured Employer Guaranty Fund. For details, see our website (www.dli.pa.gov) or call the Bureau of Workers' Compensation, toll free, at 800-482-2383 or locally and outside Pennsylvania at 717-772-4447.

What is covered?

If your work causes an injury, illness or disease, you may be entitled to WC. No compensation shall be paid when an injury or death is intentionally self-inflicted, or is caused by an employee's violation of the law including, but not limited to, the illegal use of drugs. An injury or death caused by intoxication also may not be covered.

When am I covered?

Coverage begins on the date of hire. Medical benefits are payable from the first day of injury; payment of lost wages is addressed on Page 3.

How do I get the benefits?

Prompt reporting is the key. Report any injury or work-related illness to your employer or supervisor immediately. You must tell your employer that you were injured in the course of employment and inform your employer of the date and place of injury. Failure to notify the employer can result in the delay or denial of benefits. Once you have lost a day, shift or turn of work, your employer is required to report your injury to the Bureau of Workers' Compensation by filing a first report of injury.

The employer may choose to either accept or deny the claim. If your claim is denied, you have the right to file a claim petition with the bureau for a hearing before a WC judge.

What are the benefits?

The law provides several types of workers' compensation benefits:

Payments For Lost Wages

Wage-loss benefits are available if it is determined that you are totally disabled and unable to work or partially disabled and receiving wages less than your pre-injury earnings. Please see the Total and Partial Disability Benefits Status section for further information as to disability status.

Death Benefits

If the injury results in death, surviving dependents may be entitled to benefits.

Specific Loss Benefits

If you have lost the permanent use of all or part of your thumb, finger, hand, arm, leg, foot, toe, sight, hearing or have a serious and permanent disfigurement on your head, face or neck, you may be entitled to a specific loss award.

Medical Care

Employers are responsible for advising workers of their rights and duties under Section 306(f.1)(1)(i) of the Act. The written notice of these rights and duties is to be provided to the employee at the time of injury or as soon after the injury as is practicable.

In the event of a work-related illness or injury, you are entitled, if covered under the Act, to the payment of related reasonable surgical and medical services rendered by a physician or other health care provider.

Medicine, supplies, hospital treatment and services, orthopedic appliances and prostheses are also covered for as long as they are needed. (To assure payment of medical services, see the Choice of Doctor section.) Even if you have lost no time from work, health care costs for a work-related injury or illness are payable at the fee schedule rate. However, an employee may not be charged the difference between the health care provider's charge and the amount paid by the employer or its insurance carrier. In other words, there can be no balance billing to you.

If you seek medical treatment outside Pennsylvania, you may be subject to the risk of balance billing by the medical provider. You should discuss this with your medical provider prior to initiating treatment.

Choice of Health Care Provider

You are free to choose your own health care provider to treat your work injury unless the employer accepts your claim and has posted in your workplace a list of six or more physicians or health care providers. You are required to visit a provider on the list for initial treatment. You are to continue treatment with that provider or another on the list for a period of 90 days following the first visit. You may see any provider on the list; your employer may not require or direct you to any specific provider on the list.

If a listed provider prescribes invasive surgery, you are entitled to a second opinion that will be paid for by your employer/insurer. Treatment recommended as a result of the second opinion must be provided by a listed provider for 90 days.

If during the 90-day period you visit a provider(s) not on the list, your employer or your employer's insurance carrier may refuse to pay for such treatment. After the 90 days, and in situations where your employer has no posted list or an improper list, you may seek treatment with any physician or other health care provider you select. You must notify your employer of the provider you have selected. During treatment, the employer or the employer's insurance carrier is entitled to receive monthly reports from your physician or provider.

Injured workers should be advised that your health care providers may need information concerning your claim. Some of this information may be contained in correspondence you receive from your insurance carrier, and you may want to provide copies of letters or forms to your health care provider.

Once you begin receiving WC benefits, the employer/insurer has the right to ask you to see a doctor of their choice for examination. If you refuse, the employer is entitled to request an order from the WC judge requiring you to attend an examination. Failure to then attend may result in a suspension of your benefits.

Occupational Disease

Occupational diseases under the Act are covered if caused by or aggravated by employment. Your disability must occur within 300 weeks of your last employment in an occupation where you were exposed to the hazard.

For certain lung diseases, you must have worked in an occupation with a silica, coal or asbestos hazard for at least two years in Pennsylvania during the 10 years prior to your disability.

Total and Partial Disability Benefits Status

Total Disability Benefits Status

Applies to injured workers for a period during which they are considered totally disabled and unable to work. After 104 weeks of such status, the employer/insurer can require a medical examination to determine if the employee is at least 35 percent impaired based upon his/her work injury according to American Medical Association standards. If the 35 percent threshold is not met, the employee's status can change to partial disability.

Partial Disability Benefits Status

This benefit status is for a maximum of 500 weeks. If, while on partial disability status, you obtain a qualified impairment-rating physician's determination of impairment that is equal to or greater than 35 percent, you may file a petition for reinstatement of total disability status.

Partial disability of up to 500 weeks of benefits are paid if you can, or do, return to work at a lower paying job within work-related restrictions or you are found not totally disabled.

How much are the payments for lost wages?

Wage-loss benefits are equal to approximately two-thirds of your average weekly wage, up to a weekly maximum. WC wage-loss benefits can be offset for 50 percent of Social Security (old age) benefits, the employer-paid portion of a retirement pension, severance pay, unemployment compensation or other earnings the employee receives. The law does not allow for a cost-of-living increase.

There are several different ways to calculate the average weekly wage under the Act. The minimum compensation rate is the lower of 90 percent of the workers' average weekly wage or 50 percent of the statewide average weekly wage.

Reporting Wages and Other Benefits Received

Under the Act, any worker who has filed a petition for total or partial disability benefits or who is receiving such benefits is required to report, in writing to the insurer, any information that is relevant in determining entitlement to, or amount of, compensation including, but not limited to, information regarding the receipt of wages from another employer or from self-employment. The worker is obligated to cooperate with the carrier in an investigation of employment, self-employment, wages and physical condition.

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Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

Insurance Fraud is a Crime

The above-mentioned reports and other WC forms must be honestly completed to avoid violating PA fraud provisions.

When are wage-loss payments made?

You must be disabled more than seven calendar days (including weekends) before WC payments for disability are payable. Benefits for time lost from work are payable on the eighth day after injury. Once you have been off work 14 days, you receive retroactive payment for the first seven days.

If you report the injury promptly, miss more than seven days of work and your claim is accepted by the insurance carrier, you should receive your first compensation check within 21 days of your absence from work. After that, you will receive a check on a regular basis.

Payments of temporary compensation may be made by your employer or the insurance carrier for up to 90 days, even if your claim is not accepted by your employer or its insurance carrier. If your employer or the company's insurance carrier advises you that it will not continue your temporary compensation checks past 90 days, or if they deny your claim, you have the right to file a claim petition with the Office of Adjudication for a hearing if you believe you are entitled to benefits.

Offer of Employment

If, after you begin to receive benefits, your employer has evidence to prove that employment is available to you, within your medical restrictions and in your local area, you may receive an offer of employment.

If you decline the job offer, the employer may then petition a WC judge to either reduce or stop your wage-loss benefits based upon that job. The insurer/employer must continue to pay benefits during the hearing process unless the judge orders otherwise.

In open hearings, the judge will hear and receive medical evidence, both from you and your insurer/employer, on the availability of the work and your ability to do it, before rendering a decision.

When Wage-Loss Payments Stop

Wage-loss benefits can be stopped by an employer/ insurer that has evidence that you have returned to work at wages equal to or more than your earnings level prior to the injury and after providing a timely notice of that fact. If you are receiving temporary compensation benefits during the 90 days following the report of injury, the insurance carrier/employer may notify you they are stopping benefits because they are not accepting the claim of a work-related injury.

Other reasons that benefits may be stopped include, but are not limited to: a WC judge stopped benefits after a hearing; the employee signs either a supplemental agreement or an agreement to stop workers' compensation (commonly referred to as a final receipt); the 500-week period of partial disability status expires.

What if there is a problem?

If you think you haven't received benefits that you are due, contact your employer or your employer's insurance carrier. The insurance carrier is allowed 21 days from your notice to the employer of your disability to decide to accept or deny your claim or to make payments of temporary compensation for up to 90 days.

Cooperative communication with your insurance carrier and employer is recommended. If the problem is not resolved, it may be necessary for you to file a petition with the Office of Adjudication. Forms can either be obtained online at www.dli.pa.gov or through the Claims Information Helplineat 800-482-2383. The Office of Adjudication is responsible for resolving disputes by assigning petitions to WC judges who decide each case after holding hearings on the issues.

Time Limits

Unless an employer has knowledge of the injury or the employee gives notice to the employer within 21 days of the injury, no compensation is due until notice is given. Notice must be given no later than 120 days after the injury for compensation to be allowed. If your request for WC benefits is denied by your employer or your employer's insurance carrier, you have three years from the date of injury to file a claim petition.

In occupational disease cases, injury/disability must occur within 300 weeks from the date of last employment in an occupation in which you had exposure to a hazard, and a petition must be filed no later than three years from the date of injury/disability.

Failure to file a petition on a timely basis may result in forfeiture of your right to benefits.

If your benefits were terminated, you may file a petition to reinstate WC benefits within three years after the date of your most recent WC check.

If your benefits were suspended, you may file a petition to have benefits reinstated. This petition must be filed within 500 weeks from the date of suspension.

Payment of medical benefits by your employer does not mean that your claim has been accepted or reopened.

Alternative Dispute Resolution

In alternative dispute resolution, a WC judge helps the parties settle the case by talking through their differences. Alternative dispute resolution may take the form of mediation, settlement conference or informal conference.

If either you or your employer files a petition with the Office of Adjudication, the WC judge will schedule mediation unless a judge determines it would be futile. If the case does not settle at this mediation, the parties may resume mediation or a settlement conference later in the proceedings. The parties may also request mediation or a settlement conference later in the proceedings if the judge had previously found mediation to be futile.

You may also request an informal conference to try to resolve your issues. If you are not represented by an attorney at an informal conference, your employer is not entitled to be represented either. Informal conference forms are available online at www.dli.pa.gov or through the Bureau of Workers' Compensation Claims Information Helpline at 800-482-2383.

Do I need an attorney?

You may represent yourself in WC proceedings, but a non-attorney cannot represent you. However, you should be aware that WC litigation is complex, and your employer or your employer's insurance carrier will be represented by an experienced attorney. If you hire an attorney, you should discuss fee and cost arrangements. The fee agreement must be approved by a WC judge or the Workers' Compensation Appeal Board. Your local bar association, or the Pennsylvania Bar Association's Lawyer Referral Service at 800-692-7375, can help you find an attorney.

Appeals

WC judge decisions can be appealed to the Workers' Compensation Appeal Board and then to Commonwealth Court. You will be informed of appeal rights upon receiving the WC judge's decision.

Other Benefits

If the injury is a very serious one where you won't be able to work for a year or more you may be eligible for additional disability benefits from Social Security. For information, visit the Social Security Administration's website at www.socialsecurity.gov or contact your nearest Social Security Administration office.

General Information

If you require a special accommodation to participate in a hearing due to a physical impairment, or need a sign language interpreter or an interpreter for your own language other than English, without cost, request one online at www.dli.pa.gov or contact the Bureau of Workers' Compensation Helpline and describe the accommodation:

Email: ra-li-bwc-helpline@pa.gov

Helpline voice telephone numbers:
toll free in Pennsylvania: 800-482-2383
local and outside Pennsylvania: 717-772-4447

Only people with hearing loss:
PA Relay 7-1-1

You may also ask your employer or supervisor for information on WC or contact your employer's WC insurance carrier, your union or an attorney.

The WC Act is available on the department website at www.dli.pa.gov.

If you do not need to seek medical treatment please sign & date; Have a witness sign attesting that you signed this form, it does not have to be a witness to the incident. Retain a copy for your Records. Return Original to HR.

WORKERS' COMPENSATION
MEDICAL TREATMENT WAIVER FORM

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on _____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name: _____
Print Name

Employee Signature: _____ Date:_____
Signature

Employer: Pennridge School District
Print

Witness Name: _____
Print Full Name

Witness Signature: _____ Date:_____
Signature

PENNRIDGE SCHOOL DISTRICT

Choose an Option A, B or C; Sign & date this page; Retain a copy for your Records. Return Original to HR.

ELECTION OF COMPENSATION FORM

In Pennsylvania, if you are out of work for seven (7) calendar days or less, as a result of a work related injury, you are ineligible to receive any workers' compensation wage loss benefits and must use sick/personal leave. If however, you are out of work for eight (8) to thirteen (13) days, there is a seven (7) day "waiting period," e.g. if you miss ten (10) days of work, you may receive workers' compensation for three (3) of those days. If you end up being out of work for fourteen (14) days or more, you may be able to get workers' compensation for the entire time lost from work with no deductions. If you **do** receive wage loss benefits, the money the District owes you for sick/personal leave may be offset from your workers' compensation benefits.

This document is to ensure that you receive your preferred method of compensation for your time lost from work. Please complete the bottom portion of this document and return it to the business office as soon as possible so that payroll and attendance records can be adjusted accordingly.

In the event that my absence, because of work related injury which occurred on _____, _____, exceeds seven (7) calendar days, I choose the following method of compensation, to be applied after the first five (5) working days:

OPTION A: Exhaust all accumulated unused sick days and unused personal days, and I will only keep workers' compensation benefits received thereafter.

OPTION B: Use ____unused SICK and ____unused PERSONAL days, and I will only keep workers' compensation benefits received thereafter. (Please specify number of days)

Workers' Compensation Offset: *I understand that the election of Option A or Option B above will require that I endorse and turn over to the District any workers' compensation benefits I received for days during which I also received payment from the Pennridge School District.*

OPTION C (*default*): Do not use any accumulated unused sick or unused personal days, and I will keep all workers' compensation received as a result of this absence.

I acknowledge that I will be billed for my bi-weekly health/dental insurance co-pays during my time off if I currently have this deduction from my paycheck. _____yes ____no

I would like to receive PSERS Years of Service credit during this time off: _____yes ____no
I acknowledge that I will be billed for my contribution amount during my time off.

_____ _____
Employee Signature Date

_____ _____
Tara Mossman, Director of HR Date