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 **Housing and Redevelopment Insurance Exchange.**

Claims and requests for information are to be addressed to:

Excalibur Insurance Management Services, LLC
423 Jefferson Avenue
Scranton, PA 18510

Phone: (570) 961-5105
Fax: (570) 961-2178

Expiration Date of Policy – July 1, 2021

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

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 a Housing and Redevelopment Insurance Exchange Compensation participant your claims are to be reported to:

Excalibur Insurance Management Services, LLC
423 Jefferson Avenue
Scranton, PA 18510
Phone: (570) 961-5105
Fax: (570) 961-2178

Northeastern Education Intermediate Unit 19

Your Workers' Compensation Insurance Carrier is:

Excalibur Insurance Management Services LLC
213 Smith Street Dunmore, PA 18512
Phone: 570-969-4074

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. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.

3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

4. 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.

5. 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 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 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.

6. 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.

Name	Address	Phone	Area of Specialty
*Regional Hospital of Scranton	746 Jefferson Avenue Scranton, PA 18510	570-770-3000	Emergency Medicine
*Geisinger - Community Medical Center	1800 Mulberry Street Scranton, PA 18510	570-703-8000	Emergency Medicine
DISA Global Solutions (Multiple Locations)	1000 Meade Street, Medical Plaza Dunmore, PA 18512	570-209-7160	Occupational Medicine
Northeastern Rehab Rapid Care	5 Morgan Highway, Suite 4 Scranton, PA 18508	570-207-0950	Occupational Medicine
Commonwealth Health Orthopedics (Multiple Locations)	6011 State Route 6 West Tunkhannock, PA 18657	570-836-7600	Orthopedics
Coordinated Health Scranton Orthopedics	334 Main Street Dickson City, PA 18519	570-307-1767	Orthopedics
Hand Surgery Associates	109 Terrace Drive Olyphant, PA 18447	570-483-4603	Orthopedics - Hand
Delta Medix	300 Lackawanna Avenue Scranton, PA 18503	570-344-1231	General Surgery
Professional Neurological Associates	235 Main Street, Suite 115 Dickson City, PA 18519	570-963-8803	Neurology
Northeastern Eye Institute (Multiple Locations)	503 South State Street Clarks Summit, PA 18411	570-587-5186	Ophthalmology
Perfilio Chiropractic	614 Morgan Highway Clarks Summit, PA 18411	570-586-7778	Chiropractic
Brown Chiropractic	1767 Quincy Avenue Dunmore, PA 18509	570-341-5544	Chiropractic

* Follow-up at a panel Occupational Medicine provider for continuing treatment.

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	**Call Toll Free for Closest Location**	**1-888-594-4001**	**Physical Therapy**
Premier Comp MRI Network	**Call Toll Free for Closest Location**	**1-888-594-4001**	**MRIs**
Alius Health, LLC	**Prescription Card Accepted at All Pharmacies**	**1-844-661-4463**	**Pharmacy RX**

Panel Date: 11/15/2019

I have read all of the above regarding treatment for my Workers' Compensation injury.

Employee Signature _____ **Date** _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY (MONTH - DAY - YEAR)

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY | PHONE NUMBER

EMPLOYEE: MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ | NUMBER OF DEPENDENTS | DATE OF BIRTH (MONTH - DAY - YEAR)

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN) | EMPLOYMENT STATUS (FT = Full-time, PT = Part-time, SL = Seasonal, VO = Volunteer, ZZ = Other)

EMPLOYER: NEIU

STREET ADDRESS: 1200 LINE ST

CITY: ARCHBALD | STATE: PA | ZIP CODE: 18403-

SIC CODE | EMPLOYER FEIN: 24-6001023 | PHONE NUMBER: 570-876-9200

COUNTY: LACKAWANNA | NAICS CODE

FULL PAY FOR DAY OF INJURY? YES ☐ NO ☐ | TIME EMPLOYEE BEGAN WORK AM ☐ PM ☐ | TIME OF OCCURRENCE AM ☐ PM ☐

344 1197-1

LAST DAY WORKED (MONTH - DAY - YEAR) | DATE DISABILITY BEGAN (MONTH - DAY - YEAR)

DATE EMPLOYER NOTIFIED (MONTH - DAY - YEAR) | DATE RETURNED TO WORK (MONTH - DAY - YEAR) | DATE OF HIRE (MONTH - DAY - YEAR)

CONTACT FIRST NAME | CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

LIBC 344

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES ☐
NO ☐

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH
MONTH - DAY - YEAR

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

POLICY PERIOD FROM:
MONTH - DAY - YEAR

POLICY PERIOD TO:
MONTH - DAY - YEAR

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME: HARIE/EXCALIBUR INSURANCE MANAGEMENT SERVICES LLC
STREET 213 SMITH STREET
CITY DUNMORE STATE PA ZIP 18512
BUREAU CODE: 2207 FEIN:

DATE PREPARED
MONTH - DAY - YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

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: ⓞ Injury ⓞ Illness ⓞ Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? ⓞ Yes ⓞ 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? ⓞ Yes ⓞ No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? ⓞ Yes ⓞ 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

What to do if you are injured at work?

As soon as practicable, report the incident to your Supervisor and Human Resources to 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 e-mail.

Your employer will file your claim with Excalibur Insurance Management, who will assign a representative to your claim to work with your going forward.

- If you require medical treatment, your employer will provide you with a claim number.
- When seeking medical attention for a work-related injury, tell the medical provider that yours is a Workers' Compensation injury.

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

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 Excalibur representative.

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 acknowledgement 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 NEIU 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 the 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

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.