

Dear Employee,

When you are injured, become ill, or have an incident at work you may be entitled to workers' compensation. (If you sustain a job injury or a work-related illness, the Pennsylvania Workers' Compensation Act (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.)

The Employee Notification & Acknowledgement attached outlines your rights and responsibilities under the Act. In addition to those rights you have additional responsibilities you should be aware of, they are listed below.

Employee Responsibilities:

- ✓ Notify your supervisor and HR of your injury, illness, or incident immediately (no matter how minor).
- ✓ Complete an incident report within 24 hours of occurrence.
- ✓ Seek medical attention with a provider on our panel for the first 90 days. You may see any physician you choose after 90 days.
- ✓ In the event of an emergency go directly to the nearest hospital and contact HR as soon as possible. Leave a voicemail message if necessary.
- ✓ Inform doctor that modified duty will always be considered.
- ✓ Submit medical certification to your supervisor and HR after each appointment.
- ✓ Work within the restrictions set forth by your treating physician.
- ✓ Notify your supervisor and HR in advance of your doctor appointments.
- ✓ Report any unsafe working conditions or hazards to your supervisor.
- ✓ FMLA (The Family and Medical Leave Act) will run concurrently with your workers' compensation. If you are off work for three or more days HR will provide you with FLMA paperwork. Please make sure you read the memo indicating what your responsibilities are. FMLA will be administered in compliance with the Steinman Communications FMLA policy.
- ✓ If you are off work due to a work related illness or injury, illness pay may not apply. If you are off less than 14 days, the company benefit will pay an illness benefit. If you are off more than 14 days, then our workers' compensation insurance company (PMA) will pay the employee lost wages, retroactive to the first day of lost time. SSBA benefits do not apply to workers' compensation claims.
- ✓ You must make arrangements with Human Resources to pay for your benefits while you are out on leave.

Claims can be mailed to: Gallagher Bassett
 PO Box 2831
 Clinton, IA 52733-2831

As your employer, we also have responsibilities which are listed below:

Employer Responsibilities:

- ✓ Notify our workers' compensation carrier or TPA (Third Party Administrator) of your injury, illness, or incident in a timely manner.
- ✓ Investigate the incident to determine how and why the incident occurred.
- ✓ Identify corrective measures; make changes and improvements as necessary to avoid recurrence.
- ✓ Consider modified duty.
- ✓ Inform you of FMLA eligibility.

If you have any questions regarding your claim (claim #, verification of coverage, etc.) please contact Amanda Carmichael, (717) 295-5067 or by email, acarmichael@steinmancommunications.com.

Occupational Medicine

Lancaster General (LG) Occupational Medicine
2110 Harrisburg Pike, Suite 21
Lancaster, PA 17601
717-544-3155

LG Urgent Care
Route 30 & Rohrerstown Road
2118 Spring Valley Road
Lancaster, PA 17601
717-544-0150

LG Urgent Care
Routes 322 & 222
895 East Main Street
Ephrata, PA 17522
717-721-4585

Concentra Medical Center
113 Butler Avenue
Lancaster, PA 17601
717-391-3087

Wellspan Occ Health
446 North Reading Road
Ephrata, PA 17522
717-721-4760

Workplace Partners
435 South Kinzer Avenue
Garden Spot Village
New Holland, PA 17557
717-351-2419

Wellspan Family Medical Center-Rothsville
2320 Rothsville Road
Lititz, PA
717-721-4200

MedExpress Urgent Care
4 Rohrerstown Raod
Lancaster, PA 17603
717-299-3627

Orthopedics

Lancaster Orthopedic Group (LOG)
231 Granite Run Drive
Lancaster, PA 17601
717-560-4200

LOG
703 Lampeter Road
Lancaster, PA 17602
717-560-4200

LOG
175 Martin Ave, Suite 315
Ephrata, PA 17522
Ephrata Health Pavilion
717-560-4200

LOG
1009 East Main Street
Mt. Joy, PA 17552
717-560-4200

Orthopedic Associates of Lancaster (OAL)
170 North Pointe Blvd.
Lancaster, PA 17601
717-299-4871

OAL
212 Willow Valley Lakes Dr,
Suite 201
Willow Street, PA 17584
717-517-5043

Neurological

LGHP Penn Medicine Neurology
1969 Charter Lane Ste 101
Lancaster, PA 17601
717-396-9167

Ophthalmology

Eye Physicians of Lancaster
810 Plaza Boulevard
Lancaster, PA 17601
717-735-6700

Chiropractic

Wenger Chiropractic
1516 Lititz Pike
Lancaster, PA 17601
717-397-5810

Wenger Chiropractic
512 East Main Street
Ephrata, PA 17522
717-738-2409

Physical Therapy

Drevna Physical Therapy
160 North Pointe Blvd, Suite 113
Lancaster, PA 17601
717-569-4184

Rivera Physical Therapy
190 North Pointe Blvd, Suite 2
Lancaster, PA 17601
717-392-8897

NOTICE TO ALL EMPLOYEES

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY.

If you are injured while at work, it is your responsibility to immediately report the injury to your supervisor. Your employer has provided for the payment of benefits under the Workers' Compensation Act of PA with:

Gallagher Bassett
2850 Golf Road
Rolling Meadows, IL 60008-4050

Claims Address:
Gallagher Bassett
PO Box 2831
Clinton, IA 52733-2831

In the event of a work related injury or illness you must treat with a medical provider listed on the other side of this page in order to ensure that your medical treatment is paid for.

If you suffer a work related injury or illness, expenses will be paid for reasonable and necessary surgical and medical services, medicines, supplies, orthopedic appliances and prostheses, including training in their use.

You must continue to visit one of these physicians for 90 days from the date of your first visit. After this 90-day period, if you still need treatment, you may choose to go to another physician or other health care provider for treatment. If this situation should arise, let your employer know within 5 days of the first visit.

All physicians and other health care providers must file reports within 10 days after your first visit and at least once a month for as long as treatment continues in order for payment to be considered. If one of the physicians or other health care providers listed above refers you to another physician or health care provider your employer or his insurer will pay the reasonable bills for these services.

If you are faced with an immediate medical emergency, you may secure initial assistance from a hospital, physician or other health care provider of your choice. You must then seek subsequent treatment from a physician or other health care provider listed above for at least the first 90 days from the date of your first treatment.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ and you choose that opinion, the panel physician will abide by same for 90 days.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Requests for additional information should be directed to the Human Resources Office at 717-295-5067.

Revised June 2020

EMPLOYEE & SUPERVISOR INCIDENT REPORT☐

INJURY

☐

ILLNESS

PROPERTY DAMAGE

OTHER

This report ensures there is a record of the incident on file and helps Steinman Communications provide a safe work environment. I work for:

Susquehanna Printing

Lancaster Farming

LNP Media Group, Inc.

The Pressroom

Instructions: The supervisor is responsible for assuring that all employee incidents, injuries, illnesses and property damage is/are reported to HR within 24 hours of the incident (no matter how minor). If employee is unable to complete the front page of this form, the supervisor must complete on the employee's behalf. This completed form goes to H.R.

Employee Completes this side: (All questions must be answered)

Name:		Company & Department:	
Position/Job Title:		Employment Status (circle one): Full Time Part Time w/ Benefits Part Time No Benefits Seasonal	
Social Security Number:	Date of Birth:	Hire Date:	Pay Frequency Biweekly
		Marital Status	
Days and hours normally worked: Monday ____ hours Tuesday ____ hours Wednesday ____ hours Thursday ____ hours Friday ____ hours Saturday ____ hours Sunday ____ hours			
Home Address:			
Home or Cell and Work Numbers:		email address:	Dependents Gender
Incident Information (All questions must be answered)			
Accident Date:	Accident Time:	Date Employer Notified:	Work Start Time:
Specific Injury:		Injured Body Part:	
<input type="checkbox"/> Abrasion, Scrape <input type="checkbox"/> Head Injury <input type="checkbox"/> Bruise <input type="checkbox"/> Illness <input type="checkbox"/> Concussion <input type="checkbox"/> Laceration/Cut/Puncture <input type="checkbox"/> Foreign Body <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Fracture <input type="checkbox"/> Other:		Right Left Both Description of injury & how it occurred:	
What tasks were you involved in leading up to injury:			
Where did the injury occur:		Were safeguards or safety equipment provided (circle one): Yes No N/A	
If yes, what safety equipment was used:		If no, why not:	
List equipment, materials, or chemicals you were using when incident occurred:			
Did you require outside medical treatment: Yes No		If yes, where (name & telephone number of medical facility):	
Did anyone witness the incident:		If yes, please provide witness name & telephone number:	
Employee Signature:			Date:

Supervisor Must Complete Back Of Report

Supervisor Completes this side of Incident Report (all questions must be answered)

Supervisor Name:		Supervisor Phone Number:				
		Supervisor Email:				
Date of incident:	Time of incident:	Time employee began work:	Date you were notified of incident			
Did employee complete his/her shift:	If no, time employee stopped work:		Will employee seek medical treatment:			
Medical Provider: Name & phone number						
Describe the nature of injury or illness:						
How & why did this incident occur (Direct Cause):						
What events or things contributed to this incident (Contributing Factors):						
Is this a routine task for the employee: If no, how often is task performed:						
What corrective action will be taken to prevent this from happening again:						
Were the procedures reviewed with the employee during orientation:						
Initial Cause <input type="checkbox"/> Struck by or against object <input type="checkbox"/> Caught in/under/between <input type="checkbox"/> Caught by/with <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Material Handling/Lifting <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Over-Exertion <input type="checkbox"/> Chemical Exposure <input type="checkbox"/> Explosion <input type="checkbox"/> Needle Stick Puncture <input type="checkbox"/> Animal Bite <input type="checkbox"/> Vehicular Accident <input type="checkbox"/> Other		Contributing Conditions and Behaviors <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> Equipment <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Equipment Unavailable <input type="checkbox"/> Improper Equipment Used PPE <input type="checkbox"/> Not Worn <input type="checkbox"/> Not Readily Available <input type="checkbox"/> Not Adequate for the Task <input type="checkbox"/> PPE Failure Training/Experience <input type="checkbox"/> Lack of Training <input type="checkbox"/> Protocol not followed <input type="checkbox"/> New task/lack of Experience </td> <td style="width:50%; vertical-align: top;"> Work Area <input type="checkbox"/> Housekeeping Issues <input type="checkbox"/> Ergonomic Factors <input type="checkbox"/> Ventilation Issues <input type="checkbox"/> Other (explain) </td> </tr> </table>		Equipment <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Equipment Unavailable <input type="checkbox"/> Improper Equipment Used PPE <input type="checkbox"/> Not Worn <input type="checkbox"/> Not Readily Available <input type="checkbox"/> Not Adequate for the Task <input type="checkbox"/> PPE Failure Training/Experience <input type="checkbox"/> Lack of Training <input type="checkbox"/> Protocol not followed <input type="checkbox"/> New task/lack of Experience	Work Area <input type="checkbox"/> Housekeeping Issues <input type="checkbox"/> Ergonomic Factors <input type="checkbox"/> Ventilation Issues <input type="checkbox"/> Other (explain)	
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What action has been taken or is planned to prevent recurrence: <table style="width:100%;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> Use safer materials/supplies <input type="checkbox"/> Improve Lighting <input type="checkbox"/> Improve Ventilation <input type="checkbox"/> Mandatory New Task Instruction <input type="checkbox"/> Job re-assignment of Employee <input type="checkbox"/> Improve Inspection Procedure </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> Improve clean-up procedure <input type="checkbox"/> Communicate corrective actions <input type="checkbox"/> Require PPE <input type="checkbox"/> Repair/Replace PPE <input type="checkbox"/> Improve design/construction <input type="checkbox"/> Eliminate Congestion </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> Re-training of EE involved <input type="checkbox"/> Warning to EE involved <input type="checkbox"/> Discipline of EE involved <input type="checkbox"/> Other </td> </tr> </table>				<input type="checkbox"/> Use safer materials/supplies <input type="checkbox"/> Improve Lighting <input type="checkbox"/> Improve Ventilation <input type="checkbox"/> Mandatory New Task Instruction <input type="checkbox"/> Job re-assignment of Employee <input type="checkbox"/> Improve Inspection Procedure	<input type="checkbox"/> Improve clean-up procedure <input type="checkbox"/> Communicate corrective actions <input type="checkbox"/> Require PPE <input type="checkbox"/> Repair/Replace PPE <input type="checkbox"/> Improve design/construction <input type="checkbox"/> Eliminate Congestion	<input type="checkbox"/> Re-training of EE involved <input type="checkbox"/> Warning to EE involved <input type="checkbox"/> Discipline of EE involved <input type="checkbox"/> Other
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Comments:						
Supervisor Signature:			Date:			
Human Resources Signature:			Date:			

**LNP MEDIA GROUP, INC., STEINMAN COMMUNICATIONS,
LANCASTER FARMING, SUSQUEHANNA PRINTING OF
LANCASTER, PRESSROOM RESTAURANT**

**WORKERS' COMPENSATION
EMPLOYEE NOTIFICATION & ACKNOWLEDGEMENT**

Pennsylvania law requires employers to notify employees of their rights and duties regarding medical services provided under the Worker's Compensation Law (the Act). This notice will provide you a summary of the applicable provisions of the Act:

- Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.
- Your employer has established a medical panel, which includes at least six designated health care providers, no more than four of whom are coordinated care organizations and no fewer than three of whom are physicians. The employer has not included on this list a physician or 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.
- You have a 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.
- You have 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 the designated provider during the 90-day period.
- You have the right, during this 90-day period, to switch from one health care provider on the list to another health care provider on the list. If you do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, your employer will not have to pay for the services rendered.
- You have the right to seek treatment from a referral provider if a designated provider refers you, and your employer shall pay for treatment rendered by the referral provider.
- You have the right to seek emergency medical treatment from any provider, but subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
- You have the right to seek treatment or medical consultation from a nondesignated provider during the 90-day period, but these services shall be at your expense for the applicable 90 days.
- You have a right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by your employer, if it is reasonable and necessary.
- After the initial 90 day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.
- You have the right to seek an additional opinion from any health care provider of your choice when a designated provider prescribes invasive surgery for you. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, you shall determine which course of treatment to follow. If you opt to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on your employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

I hereby acknowledge that my employer has provided me with a copy of this "Notice of Rights and Duties". I have been informed of and I understand my rights and duties pertaining to medical treatment for work related injuries thereunder. This notice was presented to me at (check one):

- ☐ Time of hire or orientation
- ☐ Immediately after the injury, or as soon thereafter as possible
- ☐ Other: Periodic review of Worker's Compensation panel physicians and Worker's Compensation rights

Employee Signature _____ Date _____

Print Name _____

Rev 7-20

Occupational Injury Temporary Prescription ID Card

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing 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 Express Scripts Patient Care Contact Center at 844-276-2515.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

»» To the Pharmacist:

myMatrixx, an Express Scripts Company administers this 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 \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 844-276-2515.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: NAEA _____

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name

Participating Retail Network Pharmacies



A & P	Drug Emporium	Longs Drug Store	Sav-On
Acme Pharmacy	Drug Fair	Major Value	Save Mart
Albertson's	Drug Town	Marsh Drugs	Schnucks
Albertson's/Acme	Drug World	Medic Discount	Scolari's
Albertson's/Osco	Eckerd	Medicap	Sedano
Albertson's/Sav-On	Econofoods	Medistat	Shaw's
Amerisource Bergen	EPIC Pharmacy	Meijer	Shop 'N Save
Anchor Pharmacies	Network	Minyard	Shopko
Arrow	FamilyMeds	NCS HealthCare	ShopRite
Aurora	Farm Fresh	Neighborcare	Snyder
Bartell Drugs	Farmer Jack	Network	Stop & Shop
Bigg's	Food City	Pharmaceuticals	Sun Mart
Bi-Lo	Food Lion	Northeast Pharmacy	Super Fresh
Bi-Mart	Fred's	Services	Super Rx
BJ's Wholesale Club	Gemmel	Osco	Target
Brooks	Giant	P & C Food Markets	Texas Oncology Srvs
Brookshire Brothers	Giant Eagle	Pamida	The Pharm
Brookshire Grocery	Giant Foods	Park Nicollet	Thrifty White
Bruno	Hannaford	Pathmark	Times
Carrs	Harris Teeter	Pavilions	Tom Thumb
Cash Wise	H-E-B	Price Chopper	Tops
Coborn's	Hi-School Pharmacy	Publix	Ukrop's
Costco	Hy-Vee	Quality Markets	United Drugs
Cub	Jewel/Osco	Raley's	United Supermarkets
CVS	Kash n Karry	Randalls	Vons
D&W	Keltsch	Rite Aid	Waldbaums
Dahl's	Kerr	Rosauers	Walgreens
Dierbergs	Kmart	Rx Express	Wal-Mart
Discount Drugmart	Knight Drugs	RXD	Wegmans
Doc's Drugs	Kroger	Safeway	Weis
Dominicks	LeaderNet (PSAO)	Sam's Club	Winn Dixie