BARGAINING UNIT

COVID-19 Packet.

You are receiving this package for one of the following reasons:

- ☐ You developed COVID-19 symptoms[1] at work or home, OR
- ☐ You have been in close contact[2] with a person in your family household who has a probable[5] or confirmed[4] case of COVID-19, OR
- ☐ You are a suspected[3] or confirmed[4] case of COVID-19.

Please take the following next steps:

- ☐ Call your healthcare provider and/or public health authority, and follow their instructions.
- ☐ Refer to the COVID-19 Situation Matrix for employee actions and return to work criteria (pages 2–3).
- ☐ Contact your leader for alignment on how long you will be away from our facility and how you will cover your absence.
- ☐ Keep your leader updated.

NOTE: See definitions on page 4.

COVID-19 CARE & QUESTIONS:
301-730-9170

EMAIL HOTLINE:
COVID-19@MeritusHealth.com

ONLINE INFORMATION:
washcohealth.org/coronavirus-disease-2019-covid-19

LOCAL WASHINGTON COUNTY TESTING FACILITIES:

Drive-thru Center
Meritus Medical Plaza
13620 Crayton Boulevard
(across from our Maugans Avenue entrance, turn right at Taco Bell)

Walk-thru Center
Walnut Street Clinic
24 North Walnut Street

You do not have to utilize Washington County resources and are welcome to count on your community's medical resources.

Situation Matrix.

Version 2 Updated 25 June 2020

	SITUATION	EMPLOYEE ACTIONS	WORKPLACE ACCESS	RETURN TO WORK

1	**An employee develops illness symptoms[1] at home.**	• Contact healthcare provider regarding need for medical evaluation.
		• May utilize local, county, and state resources for information and instructions.
		• Follow attendance decision tree on how to cover absence.
		• Remain in contact with Manager throughout the process.
			No.	• As directed by CDC or healthcare provider.
				• If no testing is indicated or if negative COVID-19 testing:
				  ◦ As directed by healthcare provider or
				  ◦ 72 hours after fever has resolved without the use of medication, and other symptoms have improved.
				• **If COVID-19 test result is positive, move to Situation #6 for further guidance.**
				• If absence is longer than 7 days, call Concentra to be cleared to return to work.

2	**An employee develops illness symptoms[1] at work.**	• Isolate from other workers, and go home. • Refer to COVID-19 Employee Packet and follow next steps. • Contact healthcare provider regarding need for medical evaluation. • May utilize local, county, and state resources for information and instructions. • Follow attendance decision tree on how to cover absence. • Remain in contact with Manager throughout the process.	**No.**	

3	**An employee (with no symptoms[1]) who has been in close contact[2] with a person who is a suspected[3] or confirmed[4] COVID-19 case (e.g. person outside of family household).**	• Take additional precautions when at work:
		  ◦ Face covering at all times
		  ◦ Daily self-screening
		  ◦ Additional personal hygiene
		  ◦ Additional temperature screening
		• Remain in regular contact with Manager throughout the process.
			Yes.	Immediately.

4	**An employee (with no symptoms[1]) who has been in close contact[2] with a suspected[3] COVID-19 case of a person in their family household).**	• Take additional precautions when at work:
		  ◦ Face covering at all times
		  ◦ Daily self-screening
		  ◦ Additional personal hygiene
		  ◦ Additional temperature screening
		• Remain in regular contact with Manager throughout the process.
			Yes.	Immediately.

Situation Matrix.

Version 2 Updated 25 June 2020

	SITUATION	EMPLOYEE ACTIONS	WORKPLACE ACCESS	RETURN TO WORK
5	**An employee (with no symptoms[1]) who has been in close contact[2] with a probable[6] or confirmed[4] COVID-19 case of a person in their family household.**	• Self-quarantine based on Volvo and/or local health department or medical providers recommendation; work from home, if possible. • Contact healthcare provider and/or public health authority if become symptomatic. • Remain in contact with Manager often throughout the process.	**No,** OR **Potential based on CDC guidance and case evaluation.**	• If no symptoms, after 14-day quarantine period (if used A&S to cover time, needs to be cleared through Concentra). • If symptomatic and negative for COVID-19 or not tested, may return as directed by healthcare provider or 72 hours after fever has resolved without the use of medication, and other symptoms have improved, and 14-day quarantine period completed. • If applying CDC Critical Infrastructure Employee exception, may return under additional controls.

6	**Suspected[3] or Confirmed[4] COVID-19 Case.**	• Do not come to work.
		• Follow instructions from medical provider and public health authority.
		• Remain in contact with Manager often throughout the process.
			No.	• As directed by CDC or healthcare provider.
				• If no testing:
				  • 72 hours after fever has resolved without the use of medication, other symptoms have improved and it has been at least 14 days since symptoms began.
				• If tested:
				  • Fever resolved without use of medication, other symptoms improved, and have 2 negative tests in a row, at least 24 hours apart
				• If asymptomatic, but confirmed positive:
				  • 14 days following first positive test, and no symptoms since test; OR, have 2 negative tests in a row, at least 24 hours apart
				• Return only after being cleared by medical provider.
				• If absence is longer than 7 days, call Concentra to be cleared to return to work.

COVID-19 Case Definitions.

1. **Common Symptoms (CDC Guidelines):**
   Fever, cough, shortness of breath, difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell. This list is not all possible symptoms. Other less common symptoms have been reported, including gastrointestinal symptoms like nausea, vomiting, or diarrhea.

2. **Close Contact:**
   Within 6 feet of person with confirmed[4] or probable[5] COVID-19 for at least 15 minutes.

3. **Suspected Case:**
   A person with
   - Acute respiratory illness (fever and at least one sign/symptom of respiratory disease) AND travel or residence in a location with community transmission of COVID-19 during 14 days prior to symptom onset, OR
   - Acute respiratory illness AND having been in contact with a confirmed[4] or probable[5] COVID-19 case in the last 14 days prior to symptom onset, OR
   - Severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease), AND requiring hospitalization, AND in the absence of alternative diagnosis.

4. **Confirmed Case:**
   A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

5. **Probable Case:**
   A person for whom testing for COVID-19 is inconclusive, OR a suspected[3] case for whom testing could not be performed.

NOTE: For suspected[3] cases which, upon testing, reveal a negative result, the employee is permitted to return to work immediately if/when symptom free and without fever without use of medication.

Forms & Information.

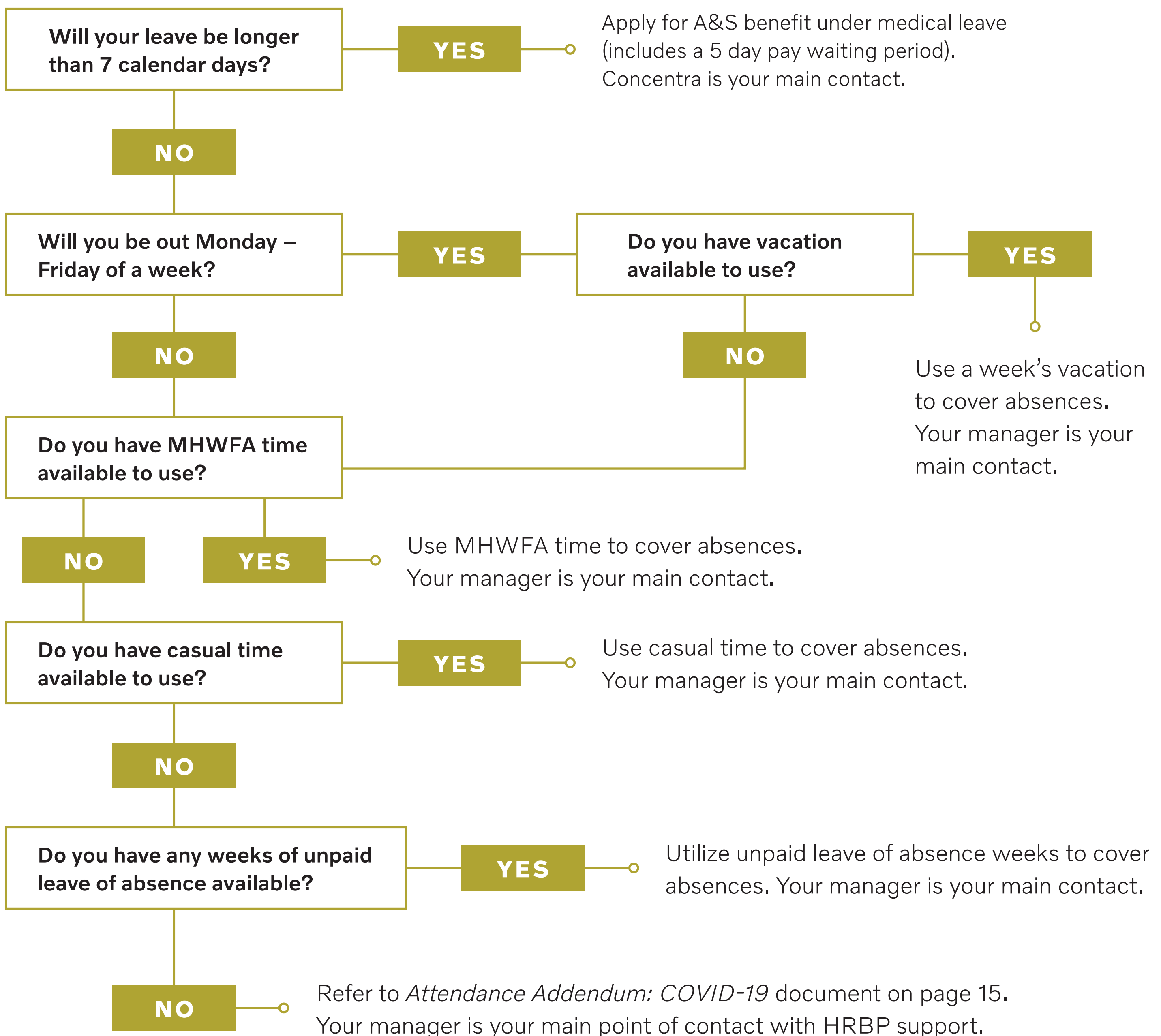
The following are included in this packet to aid you in making your decisions.

- ☐ Attendance Decision Tree: How can I cover my leave? **Pg. 6**
- ☐ 10 Things You Can Do to Manage Your COVID-19 Symptoms at Home **Pg. 7**
- ☐ A&S Occupational Health Center Checklist / Flow Sheet **Pg. 8**
- ☐ Short-Term Disability Benefit Claim Form – Part A **Pg. 10**
- ☐ Concentra Patient: Access & Authorization for Disclosure of Protected Health Information **Pg. 11**
- ☐ Employee / Provider A&S Process **Pg. 12**
- ☐ Short-Term Disability Benefit Claim Form – Part B **Pg. 13**
- ☐ Request for Return to Work Clearance **Pg. 14**
- ☐ Attendance Addendum **Pg. 15**

Refer to your COVID-19 Employee Handbook to see what we have done to slow the spread in our facility – social distancing, hand sanitizing stations, face covers, etc.

Attendance Decision Tree.

HOW CAN I COVER MY LEAVE?



10 things you can do to manage your COVID-19 symptoms at home

If you have possible or confirmed COVID-19:

1. **Stay home** from work and school. And stay away from other public places. If you must go out, avoid using any kind of public transportation, ridesharing, or taxis.

2. **Monitor your symptoms** carefully. If your symptoms get worse, call your healthcare provider immediately.

3. **Get rest and stay hydrated.**

4. If you have a medical appointment, **call the healthcare provider** ahead of time and tell them that you have or may have COVID-19.

5. For medical emergencies, call 911 and **notify the dispatch personnel** that you have or may have COVID-19.

6. **Cover your cough and sneezes.**

7. **Wash your hands often** with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.

8. As much as possible, **stay** in a specific room and **away from other people** in your home. Also, you should use a separate bathroom, if available. If you need to be around other people in or outside of the home, wear a facemask.

9. **Avoid sharing personal items** with other people in your household, like dishes, towels, and bedding.

10. **Clean all surfaces** that are touched often, like counters, tabletops, and doorknobs. Use household cleaning sprays or wipes according to the label instructions.

cdc.gov/coronavirus

CS 315822-A 04/11/2020

A&S OHC CHECKLIST

EMPLOYEE FIRST NAME	EMPLOYEE LAST NAME	SAP#	DOB
EXPECTED FIRST DAY OUT	EXPECTED RTW DATE	SUPERVISOR: HRBP:	
SHIFT	EE PHONE NUMBER		☐ Medical ☐ Hospitialization ☐ Surgery

Action	Date	Initials	Notes
A&S Packet Picked Up at OHC			
Part A Completed			
Case added to A&S Log			
Checked in and out in Occusource			
Supervisor/HR Notified via email - printed email attached			
Part B completed and received in OHC			
Extension requested (1st Extentsion)			
Extension paperwork given to employee or provider (1st)			
Supervisor/HR notified via email of extension - printed email attached			
Checked in and out in Occusource			
Extension paperwork completed and received in OHC			
Part C completed and received in the OHC			
RTW appointment scheduled			
Supervisor/HR emailed w/ RTW Physical Date - Printed email attached			
Employee completes RTW Physical			
Supervisor/HR emailed w/ RTW status - email printed			
FMLA form Completed			
FMLA forms sent to HR - email printed and attached			

Concentra

Communication Flow Sheet

Patient Name: ______________________________

Date	Notes	Initials

SHORT TERM DISABILITY BENEFIT CLAIM FORM

ANY ATTEMPT TO ALTER, MISLEAD OR FALSELY REQUEST INFORMATION WILL RESULT IN SEVERE DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION

PART A: EMPLOYEE'S STATEMENT
Questions Must be Completed by Employee and returned to address below

Full Name	**SAP #**	**Date of Birth**
Address/Street **City**		**State** **Zip**
Cell Phone or Primary Phone	☐ **GTO (Group Truck Operation)** ☐ **GTT (Group Truck Technology)**	**Supervisor**
Specific Reason for A&S: ____________________ ____________________ ____________________ ____________________	**Is the disability due to your employment with the company?** ☐ **Yes** ☐ **No**	**Do you have any other current employment outside of this company?** ☐ **Yes** ☐ **No**
Current Shift Worked ☐ **1st** ☐ **2nd** ☐ **3rd** ☐ **7th** ☐ **8th**	**Expected First Day Out of Work** **Date:** ____________	**Expected Return to Work Date** **Date:** ____________

AUTHORIZATION TO RELEASE INFORMATION

To all physicians and other medical professionals, hospitals and other medical-care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators.

- You are authorized to provide the Company (Volvo and/or Concentra) with information concerning medical care, advice, treatment or supplies provided the patient, and any other employment related information regarding me.
- THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR BENEFITS AND MAY BE REDISCLOSED TO AN INDEPENDENT CLAIM ADMINISTRATOR OR AGENCY ACTING ON THE BEHALF OF THE COMPANY AND TO ANY COMPANY WORKERS' COMPENSATION CARRIERS FOR THE PURPOSE OF EVALUATING A WORKERS' COMPENSATION CLAIM.
- I understand the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted.
- I understand that I have a right to receive a copy of this authorization upon request. I agree that a photograph copy of this authorization is as valid as the original.
- If I receive a disability benefit payment greater than that which should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any; or to recoup such overpayment by withholding monies from any Company compensation that would otherwise be due me, and I explicitly consent to such deductions, which will be taken in accordance with applicable law

______________________________ Employee's Signature   ______________________ Date

*ANY EMPLOYEE WHO ENGAGES IN GAINFUL EMPLOYMENT WHILE ON A SICK DISABILITY LEAVE MAY BE SUBJECT TO DISCIPLINARY ACTION, UP TO AND INCLUDING DISCHARGE.

*** IMPORTANT- Attending Physician must complete the following pages of this form - Part B and Part C.**

RETURN COMPLETED FORM TO:
Volvo Group Trucks (CONCENTRA Occupational Health Center)
13302 Pennsylvania Avenue
Hagerstown, MD 21742 USA
Telephone: 240-513-3590
Fax: 301-797-4975

Patient – Access and Authorization for Disclosure of Protected Health Information (PHI) HIPAA Release

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: ______________________________ Birthdate: ____________________

Address: ____

PURPOSE OF DISCLOSURE
Injury/ Non-Injury

FACILITY VISITED
Volvo Occupational Health Center

Records to be disclosed related to the following date(s) of service ____________________

☐ Complete medical record ☐ Lab Results ☐ Physician Orders ☐ Prescriptions ☐ Itemized Bill ☐ X-ray
☐ Other: ____

CONFIRMATION OF WHO MAY RECEIVE COPIES OF YOUR RECORDS

Person/Entity Name: Volvo

Address: 13302 Pennsylvania Ave City: Hagerstown St: MD Zip: 21742

Fax Number: __________ Confirmation Phone Number: __________ Email: ________________

BY: ☒ **Mail** ☒ **Call at number to pick up** ☒ **Fax** ☒ **Email**

IN CONNECTION WITH THIS AUTHORIZATION

- The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficient Syndrome (AIDS). To authorize disclosure of **any of the following sensitive information initial the applicable line(s) below**:

  ___ Alcohol / Drug Abuse Treatment / Referral ___HIV/AIDS-related Testing and/or Treatment
  ___Sexually Transmitted Diseases ___Mental Health (Other than Psychotherapy notes)
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.
- I understand that this authorization expires one year from date of authorization, unless revoked or a shorter duration is specified here______________. Additionally, applicable State Law may specify a shorter duration.
- I have a right to receive a copy of this authorization.

Patient's Signature / Date: ______________ or Signature of Patient's Representative / Date: _______

Printed Name of Patient's Representative   Explanation of your legal right to sign for Patient

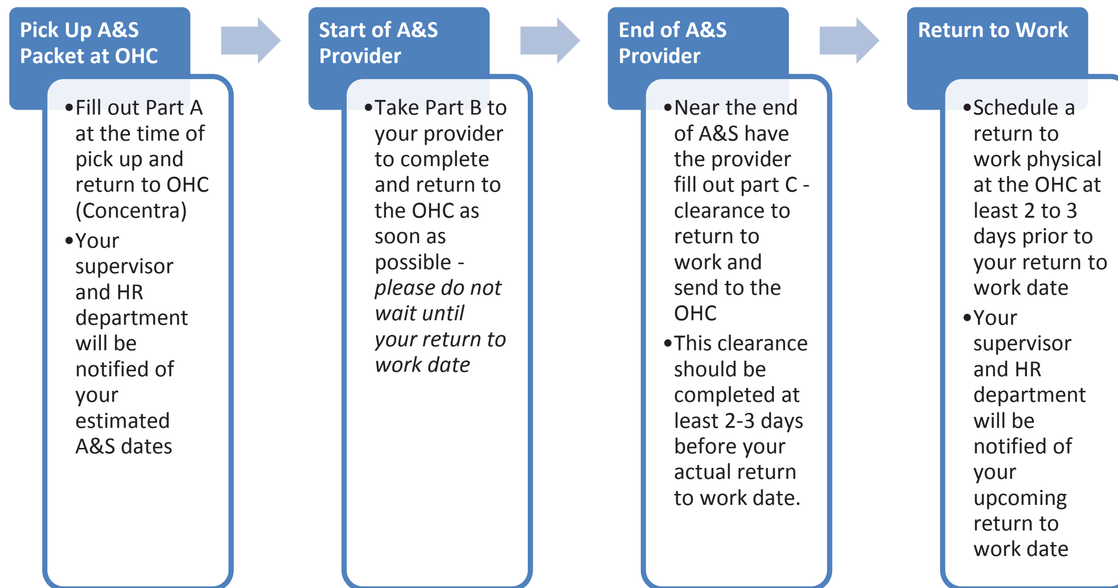
For HIPAA questions related to this form, please contact the Privacy Office at 1-800-819-5571.

Facility please complete below and email with copy of records to PrivacyOffice@Concentra.com or fax to 214.775.4408:
☐ Date request received: _______ ☐ Date sent to Privacy Office: ______ ☐ Approved ☐ Denied (reason)____________________

Privacy-Access and Authorization = 09/24/15

VOLVO

EMPLOYEE / PROVIDER A&S PROCESS



- If you are unable to pick up your own forms they can be mailed to your home address, a family member may pick them up in the OHC, or they can be emailed to you. Committemen are not allowed to pick them up.
- If your initial expected date of return to work is extended by your provider you must contact the OHC (Concentra) to request an Extenstion to be filed **BEFORE** the current A&S is set to expire. Additional paperwork will need to be completed by the provider and can be faxed or emailed to the provider.
- The OHC (Concentra) cannot perform a Return to Work Physical without Part C completed by your provider
- If your absence is more than 30 days you must report to Human Resources after your Return to Work Physical at the OHC (Concentra)
- Any delay in paperwork could result in a delay in pay.
- As a reminder, under the contract *(Master Contract, Article 10, Section 27(c)(3)),* FMLA runs concurrent with six weeks (*up to 240 hours*) of Accident and Sickness benefits. An FMLA 'Certification of Health Care Provider for Employee's Serious Health Condition' is enclosed in the packet. You doctor should complete the attached FMLA form and return it to our HR office prior to your return to work date.
- While you are on Accident and Sickness (medical leave) you are not permitted in the facility with the exception of going to the Occupational Health Center or to Family First Medical Center.
- If you have questions please reach out to the appropriate departments:

Occupational Health Center (Concentra) **(240) 513-3590 (p)** **(301) 797-4975 (f)**	**Volvo Human Resources Department** **(301) 790-5553** **(301) 790-5463**
• Schedule Return to Work Physical • Checking status of Provider paperwork • Request an extension of A&S • Pick up A&S forms • Pick up FMLA forms when in conjunction with A&S	• Pay during A&S • Points for absence • Health Insurance • FMLA when **NOT** in conjunction to A&S

RETURN COMPLETED FORMS TO:
Volvo Group Trucks (CONCENTRA Occupational Health Center)
13302 Pennsylvania Avenue
Hagerstown, MD 21742 USA
Telephone: 240-513-3590
Fax: 301-797-4975

SHORT TERM DISABILITY BENEFIT CLAIM FORM

PART B: ATTENDING PHYSICIAN STATEMENT-
ONLY YOUR DOCTOR CAN COMPLETE THIS PORTION

TO THE ATTENDING PHYSICIAN: Your patient has applied for or may be eligible for weekly disability income benefits. Your answers to the questions below will assist us in determining if these benefits are payable. Please answer ALL applicable items, otherwise the form will be returned to you for additional information.

Patients First Name	Patients Last Name	Date of Birth

Diagnosis and Concurrent Conditions

CORRESPONDING ICDA *CODE: ________________

CPT Code: ________________________________

CPT Code: ________________________________

CPT Code: ________________________________

Date Patient was First Examined for this Current Condition: ________________

Dates of Service in Doctors Office or Hospital after Initial Visit:

______________, ________________, ________________, ________________

Patient's Next Scheduled Appointment: ______________________

Is the Condition(s) due to Injury or Sickness Arising Out of Patient's Employment?

☐ Yes ☐ No

Please explain: ________________________________

____

____

____

____

Was the Patient Hospitalized? ☐ Yes ☐ No

Date Admitted: ________________ **Date Discharged:** ________________

Name of Hospital: ____

Was Surgery Performed? ☐ Yes ☐ No

Type of Procedure: ____

Date of Surgery: ______________________

Has the Patient been Referred to Another Physician?

☐ Yes ☐ No

Date of Referral: ________________

Type of Physician? ______________________________

Name of Physician? ______________________________

Additonal Notes: ____

____

____

____

APPROXIMATE DATE THAT EMPLOYEE MAY RETURN TO WORK: ________________________________

(If you are releasing the employee to return to work with or without restrictions please complete Part C - Return to Work Clearance)

____________ ________________________________ ________________________________

DATE **PHYSICIAN'S NAME (Print)** **Signature**

____

STREET ADDRESS CITY OR TOWN STATE ZIP CODE

(_______)________________________ (_______)________________________

TELEPHONE NUMBER FAX NUMBER

RETURN COMPLETED FORM TO:
Volvo Group Trucks (CONCENTRA Occupational Health Center)
13302 Pennsylvania Avenue
Hagerstown, MD 21742 USA
Telephone: 240-513-3590
Fax: 301-797-4975

REQUEST FOR RETURN TO WORK CLEARANCE

PART C: ATTENDING PHYSICIAN RETURN TO WORK CLEARANCE
ONLY YOUR DOCTOR CAN COMPLETE THIS PORTION

TO THE ATTENDING PHYSICIAN: If you are releasing an employee to return to work, and that employee continues to have a medical condition which would prevent or restrict his/her performance of regular work assignments, we require you to identify any restrictions, limitations and the type of work the employee can and cannot perform.

Patients First Name	Patients Last Name	Date of Birth

First Day Out of Work Date:	Return to Work Date:

Patient is able to return to work

□ **with NO restrictions or limitations and is ABLE to perform all regular work duties**
□ **with restrictions or limitations and is NOT able to perform all regular work duties** *(please describe below)*

Restrictions and / or Limitations *(please be specific)*

____

____

____

____

APPROXIMATE DATE FOR RESTRICTIONS/LIMITATIONS TO END AND RETURN TO REGULAR WORK: ____________________

Additional Physician's Notes

____

____

____

____________ ______________________________ ______________________________
DATE **PHYSICIAN'S NAME (Print)** **Signature**

____
STREET ADDRESS CITY OR TOWN STATE ZIP CODE

(________)______________________________ (________)______________________________
TELEPHONE NUMBER FAX NUMBER

RETURN COMPLETED FORM TO:
Volvo Group Trucks (CONCENTRA Occupational Health Center)
13302 Pennsylvania Avenue
Hagerstown, MD 21742 USA
Telephone: 240-513-3590
Fax: 301-797-4975

Special GTO PTP HAG Attendance Addendum: COVID-19

Title: Attendance Addendum: COVID-19

Duration: 04MAY thru 30JUNE2020

Eligibility: GTO PTP HAG employees who have exhausted all available paid/contractual leave and considered to be high risk or who have family m embers living in the same household who are high risk.

Summary:
With the current state of the COVID-19 pandemic, Volvo Group Hagerstown has taken many precautionary measures to aid in the health and safety of our employees. To further our efforts, we will allow employees with underlying health issue(s), or who have a family member living full-time in their own household who is high-risk, to self- disclose and who have exhausted all available leave (paid, contractual, ETO, etc.) to request an unpaid leave of absence. Our goal is to keep those who are high-risk safe, and perhaps save a life.

Consideration will be given based upon the severity of their or their family member's medical condition, providing supporting documentation of the condition or a recommendation from their or their family member's treating physician. If approved, the time-off will be coded accordingly in the timekeeping system.

Based on currently available information and clinical expertise, older adults and people of any age who have serious underlying medical conditions might be at higher risk for severe illness from COVID-19. Those at high-risk for severe illness from COVID-19 include:

- People aged 65 years and older
- Other high-risk conditions could include:
  - People with chronic lung disease or moderate to severe asthma
  - People who have heart disease with complications
  - People who are immunocompromised including cancer treatment
  - People of any age with certain underlying medical conditions, particularly if not well controlled, such as those with diabetes, renal failure, or liver disease might also be at risk
- People who are pregnant should be monitored since they are known to be at risk with severe viral illness, however, to date data on COVID-19 has not shown increased risk

- HIV/AIDS; cancer and transplant patients who are taking certain immunosuppressive drugs; and those with inherited diseases that affect the immune system

Note: The criteria above apply to employees with these conditions or employees who have a family member living full-time in their own household who has one of these conditions.

If casual time is used for emergency reasons related to COVID-19 employee will not receive any occurrences connected to that absence. Additionally, in order to receive preapproved, non-urgent casual time, the casual time must be requested with at least three (3) business days in advance to your immediate manager.

Process:
The individual will need to self-disclose and provide supporting documentation to your HRBP.

Approvals will be done as soon as administratively possible. If approved, you may take the communicated time-off and there will be no attendance occurrence assessed during this time.

This program will be reviewed periodically and is subject to be adjusted or terminated based on the change in conditions regarding COVID-19 and business needs.