APPENDIX D

FREEDOM AREA SCHOOL DISTRICT
BENEFIT ELECTION FORM

You have the opportunity to participate in the Freedom Area School District Waiver of Health Care Coverage Plan (the "Plan") and elect to receive additional taxable compensation in lieu of health insurance coverage. Complete Section 1, sign at the bottom, and return this Election Form to the Business Manager. Your compensation will be increased in the amount as listed in Section 2. Only those employees who are eligible to participate in the Freedom Area School District Health Insurance Plan and are enrolled in another group medical plan, such as a spouse's plan, or covered by an individual policy, are eligible to participate in this Plan.

Irrevocable Election If you choose to participate in this Plan, you can not change or revoke your election until the next open enrollment period for the next Plan Year that runs from January 1 through December 31 unless you have a change in status as described in the Plan. Examples of a change in status are: marriage, divorce, death of your spouse or child, birth or adoption of a child, termination of employment of your spouse, switch from part-time to full-time employment or from full-time to part-time employment, beginning an unpaid leave of absence, or where there has been a significant change in your or your spouse's health coverage attributable to the spouse's employment. The election change must be requested within 30 days of the event, and must be on account of and consistent with the change in status as defined in the Plan.

1. **Employee Information**

Name: _____ SS#: _____

2. **Election**

For the Plan Year commencing January 1, _____, I hereby elect to receive the following benefit (select only one):

___ PPO Qualified High Deductible Health Plan

___ Waiver Compensation ($2,000 per Plan Year) ($1000 if half-time)

3. **Waiver Compensation**

By electing to receive Waiver Compensation, I am waiving participation in the Health Insurance Plan. I understand that I will receive additional taxable compensation during the Plan Year in the amount of $2,000 such (or $1000 for half-time employees, or prorated) such payment being made with the December payroll. (Such additional compensation does not qualify as "compensation" as defined by the Pennsylvania State Employee Retirement Code and, therefore, is not subject to member-paid or employer-paid contributions to the Pennsylvania State Employee Retirement System).

4. **Employee Statement and Signature**

I hereby certify my election as designated above under the Freedom Area School District Waiver of Health Care Coverage Plan for the duration of the Plan Year. If I elected the Waiver Compensation benefit, I certify that I am covered for health care under another group/individual health plan as documented by my submission of such coverage. I acknowledge that I have read and understand any material (including the Summary Plan Description) concerning the effect of my election. I further understand that if I elected to waive receiving health insurance from the Freedom Area School District, I agree to hold Freedom Area School District harmless from any medical claim expenses incurred subject to group/individual health insurance plan coverage on my eligible dependents or myself. My election on this Election Form revokes any prior election relating to the same matter under the Plan. Before the beginning of each Plan Year, I will be offered the opportunity to change my election for the following Plan Year.

This Election Form is subject to the terms of the Plan as in effect from time to time and shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania to the extent not superseded by Federal law.

_____ _____

Employee's Signature Date

Administrator Use Only:

Proof of other coverage received Date: _____ Received by: _____

FREEDOM AREA SCHOOL DISTRICT-INSURANCE ENROLLMENT/CHANGE FORM

☐ New Enrollment ☐ Name Change ☐ Address Change ☐ Change of Dependents ☐ Termination

☐ COBRA

SOCIAL SECURITY NUMBER	LAST NAME	FIRST	MI	DATE OF BIRTH	SEX

ADDRESS	HIRE DATE		PHONE NUMBERS

COVERAGE OPTION

☐ Employee Only ☐ Parent/Child(ren)

☐ Employee/Spouse ☐ Family

NOTES:

Other Insurance	NAME AND ADDRESS OF CARRIER(S)	GROUP NUMBER	POLICY HOLDER	RELATIONSHIP
☐ YES ☐ NO				

3. DEPENDENT CHANGE — CHOOSE ONE PLEASE

☐ ADD DEPENDENTS LISTED BELOW ☐ DELETE DEPENDENTS LISTED BELOW

DEPENDENTS	LAST NAME	FIRST NAME	MI	STUDENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
Spouse					M F		
Child					M F		
Child					M F		
Child					M F		
Child					M F		
Child					M F		
Child					M F		

EFFECTIVE DATE OF ABOVE CHANGE(S)	REASON FOR ABOVE CHANGE(S)

EMPLOYEE SIGNATURE DATE

EMPLOYER SIGNATURE DATE

FREEDOM AREA SCHOOL DISTRICT

HSA ELIGIBILITY DETERMINATION / PRE-TAX SALARY REDUCTION ELECTION FORM – Coverage for January 1 – December 31, 2023

First Name MI Last Name

Social Security # ☐☐☐ - ☐☐ - ☐☐☐☐

I understand that if I meet the eligibility standards as defined by the IRS, my employer may make a contribution to my Health Savings Account ("HSA"). I may also elect to make pre-tax contributions to my HSA through payroll reductions. These pre-tax contributions are available under my employer's Section 125 Plan. When making this election, I further understand the 2023 contribution limits for HSAs are $3,850 for Employee Only Plans and $7,750 for Family Plans (with a catch up provision for participants age 55 years and older of an additional $1,000 over the respective category limit). This maximum contribution level is the sum of employer and employee contributions.

Please make your election below, then sign and date your form and submit it to the Payroll Office:

I certify that I meet the following requirements and thus am eligible to have a Health Savings Account ("HSA"):

- I am or will be enrolled in Qualified High Deductible Health Plan
- I am not enrolled as a dependent in a non-QHDHP coverage
- I am not enrolled in Medicare (Including active employees enrolled in Medicare Part A)
- I am not enrolled in TriCare
- I am not claimed as a dependent on another person's tax return
- I nor my spouse are enrolled in a Medical Flexible Savings Account (FSA) or Health Reimbursement Account (HRA)
- I am not receiving Social Security or Railroad Retirement Board Benefits and enrolled in Medicare Part A.

I understand that I must maintain the eligibility requirements for the current benefit period to remain eligible to ***receive and make contributions*** to my Health Savings Account.

☐ I am **not eligible**, as defined by the IRS, to be enrolled in a Health Savings Account.

☐ I **am eligible**, as defined by the IRS, to be enrolled in a Health Savings Account, and I elect to have deducted _____ per pay period, effective _____ and continuing until I change my election. I understand that my election is prospective only and that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes.

☐ I **am eligible**, as defined by the IRS, to be enrolled in a Health Savings Account and to receive employer contributions to my HSA; however, I am declining the option to make pre-tax contributions to my HSA at this time.

Employee Signature _____ Date _____

Beneficiary Designation Under Group Life Insurance Policy

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
1-800-553-5318 Fax: 1-888-285-1565
www.employeebenefits.aul.com

OneAmerica®

IMPORTANT: PLEASE READ INSTRUCTIONS AND SAMPLE DESIGNATIONS ON REVERSE SIDE BEFORE COMPLETING FORM.

CHECK IF BENEFICIARY FOR: ☑ All Policies or ☐ Basic Life ☐ Supplemental ☐ Voluntary Term Life ☐ AD&D ☐ List Other _____

Group Policy/Participating Unit Number	0062439-0000-000		
Name of Group Policyholder/Participating Unit	FREEDOM AREA SD		
Name of Insured Person			
Insured Person's SSN		Insured Person's Date of Birth	

Subject to the provisions of the policy, applicable laws, and the rights of any valid assignee of record with American United Life Insurance Company® (AUL), it is requested the beneficiary of any policy proceeds payable at the death of the Insured Person be as follows:

PRIMARY BENEFICIARY(S)

Name	*Relationship*	*Address*	*DOB*	*SSN*	*Percentage*
			Total[1]		0

CONTINGENT BENEFICIARY(S) IF THE PRIMARY BENEFICIARY(S) PREDECEASES YOU

Name	*Relationship*	*Address*	*DOB*	*SSN*	*Percentage*
			Total[2]		0

It is understood and agreed upon receipt of this beneficiary designation by AUL at its principal office, such beneficiary designation will become effective and shall relate back to the date this beneficiary designation is signed, but without prejudice to AUL on account of any payment made prior to the receipt of and acknowledgement of the validity of the beneficiary designation by AUL. AUL shall not be obligated to honor this beneficiary designation unless and until it has been received by AUL, acknowledged by the appropriate officer of AUL, and determined by AUL to comply with applicable law at the time a claim is made. This beneficiary designation supersedes and cancels all prior beneficiary designations by the Insured Person for the policy(s) indicated. If no beneficiary designation is named on any additional AUL coverage, the undersigned understands that this beneficiary designation will be used by AUL for any additional coverage.

The undersigned hereby declares that he/she has not been declared incompetent and no court order or laws prevent naming the above designee(s). It is agreed that AUL assumes no responsibility for the validity or effect of any purported beneficiary designation or transfer of rights under the policy. **The undersigned represents and warrants any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.** The undersigned understands and agrees: 1) any insurance coverage or benefits is contingent upon any statements made to AUL as being complete and correct and 2) benefits under any policy will be paid only if AUL decides the applicant is entitled to them under the policy.

Signature of Insured	*Signature of Witness* *(The Witness must have no interest in the policy/contract or be a named beneficiary)*
Printed Name	*Printed Name*
Date	*Date*

Lack of Notice of Community Property Interest: If AUL has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then AUL shall be entitled to rely upon its good faith that no such interest exists. AUL assumes no responsibility of inquiry regarding such interest and, in consideration of acknowledgement of this designation, the insured person listed above, for himself/herself and his/her estate, heirs, successors and assigns, agrees to indemnify AUL and hold it harmless from the consequences of acknowledging this beneficiary designation.

Spouse's signature and consent *(if applicable)*:[3] _____ Date _____

1 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

2 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

3 Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.freedomareaschools.org or call (724)775-7644. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call (724)775-7644 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,500 individual/$3,000 family, combined network and out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Network deductible does not apply to preventive care services. Coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$0 individual/$0 family network out-of-pocket limit, up to a total maximum out-of-pocket limit of $6,350 individual/$12,700 family. $1,500 individual/$3,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Network: Premiums, balance-billing charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket limit. Out-of-network: Premiums, deductibles, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

An example of a benefit book can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.freedomareaschools.org or call (724)775-7644.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	No charge	20% coinsurance	
	Preventive care/Screening/Immunization	No charge for preventive care services; deductible does not apply	20% coinsurance for preventive care services	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.highmarkbcbs.com.	Generic drugs	No charge (retail and mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order.
	Brand drugs	No charge (retail and mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	----------none----------
	Physician/surgeon fees	No charge	20% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room Care	$100 copay/visit	$100 copay/visit	----------none----------
	Emergency medical transportation	No charge	20% coinsurance	----------none----------
	Urgent care	No charge	20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fee	No charge	20% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge	20% coinsurance	----------none----------
	Inpatient services	No charge	20% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	20% coinsurance	Precertification may be required for inpatient facility services. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	----------none----------
	Rehabilitation services	No charge	20% coinsurance	----------none----------
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	No charge	20% coinsurance	Precertification may be required.
	Durable medical equipment	No charge	20% coinsurance	----------none----------
	Hospice service	No charge	20% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's Eye exam	Not covered	Not covered	----------none----------
	Children's Glasses	Not covered	Not covered	----------none----------
	Children's Dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://www.bcbsa.com
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer (724)775-7644.
- Highmark Inc. at 1-800-241-5704.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To obtain language assistance, call (724)775-7644.
SPANISH (Español): Para obtener asistencia en Español, llame al (724)775-7644.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (724)775-7644.
CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (724)775-7644.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (724)775-7644.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact (724)775-7644.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Shield which is an independent licensee of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.

If you speak English, language assistance services, free of charge, are available to you. Call 1-855-329-0729.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-855-329-0729.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-855-329-0729.

Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel 1-855-329-0729.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-855-329-0729.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-855-329-0729.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-855-329-0729.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-855-329-0729 નંબર પર ફોન કરો.

यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-855-329-0729 पर फ़ोन करें।

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-855-329-0729.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-855-329-0729 を呼び出します。

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-855-329-0729 로 전화.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-855-329-0729 ។

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Koji' hodíilnih 1-855-329-0729.

यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 1-855-329-0729 मा फोन गर्नुहोस्।

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-855-329-0729 uffrufe.

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-855-329-0729.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-855-329-0729.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-855-329-0729.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-855-329-0729.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-855-329-0729.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-855-329-0729.

మీరు తెలుగు మాట్లాడితే, లాగేవేవ అనెనటినన సరేపినిన, ధారేటు లేకుండా, మీకు అందుబాటులో ఉనసాయి. కాల్ చేయండి 1-855-329-0729.

หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย
โทร 1-855-329-0729.

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-855-329-0729 پر کال کریں۔

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-855-329-0729.

Delta Dental PPO℠ — Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Greatest potential savings when you visit a Delta Dental PPO dentist

OUT-OF-POCKET COSTS

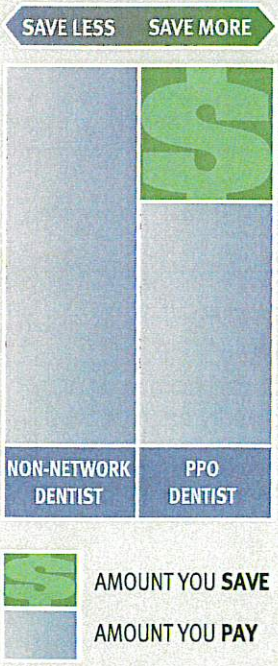

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

DELTA DENTAL®

WE KEEP YOU SMILING®

HL_PPO_2col #63452 (6/11)

Plan Benefit Highlights for: Freedom Area School District
Group No: 10002

Eligibility	Primary enrollee, spouse and eligible dependent children to age 19 or to age 23 if dependent is full-time student
Deductibles	$10 per person / $30 per family each calendar year
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes
Maximums	$1,100 per person each calendar year
D & P counts toward maximum?	Yes

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists** (Delta Dental Premier® & Non-Delta Dental Dentists)
Diagnostic & Preventive Services Exams, cleanings, x-rays	100 %	100 %
Basic Services Fillings	100 %	100 %
Endodontics (root canals) Covered Under Basic Services	100 %	100 %
Periodontics (gum treatment) Covered Under Basic Services	100 %	100 %
Oral Surgery Covered Under Basic Services	100 %	100 %
Major Services Crowns, inlays, onlays and cast restorations	100 %	100 %
Prosthodontics Bridges and dentures	0 %	0 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783
(Business Hours: 8 am to 8 pm ET)

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-2105

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

SAMPLE BENEFICIARY DESIGNATIONS

The beneficiary wording should be absolutely clear and without question as to whom the proceeds are to be paid. Listed below are sample beneficiary designations. Please note state laws may prohibit naming certain entities and individuals as a beneficiary. If you live in a community property state, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI.

To ensure the correct individual or entity receives the benefits and the intended benefit amount, please provide the following:

- The beneficiary's social security number, tax identification number and date of birth.
- Distribution of proceeds should be shown in fractions or percentages if multiple beneficiaries are designated. Do not list dollar amounts as the amount of the insured's life benefit may change. If no distribution is shown, benefits will be divided equally among the living beneficiaries.

ACCEPTABLE BENEFICIARY DESIGNATIONS

1) **One Beneficiary** – State the full name and relationship to the insured.
   Sample: John Doe, husband
2) **Two Beneficiaries in Equal Shares** –
   Sample: Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
3) **Three or More Beneficiaries in Equal Shares** –
   Sample: Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
4) **Two Beneficiaries in Succession** – If the primary beneficiary dies, the second person named will receive the proceeds and is known as the contingent beneficiary.
   Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin.
5) **Three or More Beneficiaries in succession** – If the primary and secondary beneficiaries die, the third person named will receive the proceeds.
   Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin, or in the event of his death, Jane Doe, niece.
6) **One Beneficiary Followed by Two Beneficiaries in Equal Shares** –
   Sample: Martha Doe, wife, or, in the event of her death, Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
7) **One Beneficiary Followed by Three or More Beneficiaries in Equal Shares** –
   Sample: John Doe, husband, or, in the event of his death, Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
8) **Two Beneficiaries Shown in Percentages** –
   Sample: John Smith, cousin 40%, Sally Smith, aunt 60%.
9) **Two or More Beneficiaries Shown in Percentages** –
   Sample: Mary Doe, wife 50%, Jane Doe, cousin 25%, John Doe, cousin 25%.
10) **Estate** – Do not identify the name of the executor of executrix since this name may change as wills are updated.
    Sample: Estate of John Doe
11) **Custodian for Minor Children** – Please note any minor child beneficiary designation should nominate a custodian (i.e. bank, adult, trustee) followed by the words "as custodian for *(minor child's name)* under the *(child's residential state)* uniform transfers to minors act." This designation may avoid a court appointed guardianship for the payment of the death benefit.
    Sample: John Doe as custodian for Jimmy Smith under the Indiana Uniform Transfers to Minors act.
12) **Trust Agreement** – State the name of the trust and the date of the trust agreement.
    Sample: John Doe Trust dated _____. Payment to trustee shall discharge the company.
13) **Wife or Unnamed Children** –
    Sample: Martha Doe, wife, or in the event of her death, our children, if any, or their survivors.
14) **Unnamed Children** –
    Sample: Children, if any, in equal shares, or their survivors.
15) **Beneficiary - No Relationship** –
    Sample: Mary Doe, friend
16) **To a Church or Organization** – It is preferable to indicate both the name and address and the wording "or its successors or assigns."
    Sample: Christ Lutheran Church or its successors or assigns
17) **Irrevocable Beneficiary** – This is acceptable, but not preferable, as the beneficiary must then approve any future beneficiary change.
    Sample: John Smith, husband, irrevocable beneficiary.
18) **Employee Unable to Sign** – This designation must contain the person's mark and be signed by two disinterested witnesses.

UNACCEPTABLE BENEFICIARY DESIGNATIONS

1) **Collateral assignments**, e.g. to banks, finance companies, etc. as creditors on a loan.
2) **The Employer**
3) **Funeral Homes**

Beneficiary Basics

Six steps to maximize your term life insurance and get your benefit into the right hands.

1. Choose wisely

You can name anyone a beneficiary of your life insurance, however, in nine states (AZ, CA, ID, LA, NV, NM, TX, WA, WI), your spouse must sign off on anyone else you choose. If you choose to have multiple primary beneficiaries and one dies before you, the benefit will go to your remaining primary beneficiaries. If there are no surviving beneficiaries then the benefit would go to your back-up, or contingent, beneficiaries. Keep in mind, you can't name a funeral home or your employer as beneficiaries. If you have term life insurance for your spouse or dependent, you will always be the beneficiary.

More than a quarter of U.S. households would feel the financial impact from the loss of their primary wage earner in a month or less.[1]

$6 billion

OneAmerica® paid out $6 billion in benefits in 2019.

1. **Source:** *2020 Insurance Barometer Study, LIMRA and Life Happens*

G-28626 03/23/21

2. Be thorough

When you choose your beneficiaries, be sure to list names, Social Security numbers, birth dates and addresses so we can easily find your beneficiary(ies) when we need to. The beneficiary designation form must be dated and witnessed by someone other than your beneficiary(ies).

3. Don't forget to update

Be sure to revisit your beneficiary designations whenever you have a big life event, such as marriage, divorce, new baby or if one of your beneficiaries dies.

4. Use extra care when your beneficiary is a child

We don't pay life insurance proceeds directly to minors. If you'd like to leave your benefit to someone under 18 (19 in AL and NE; and 21 in MS and Puerto Rico), work with an attorney or financial advisor to set up a trust. Or take steps to legally appoint a trustworthy adult to be responsible for managing the money on behalf of the minor. If you leave your life insurance benefit to a minor without a trust or guardianship, it can take longer and be more expensive to get your benefit into the right hands.

5. Avoid unnecessary taxes

Most of the time life insurance benefits are tax-free, but anyone who receives Supplemental Security Income or Medicaid can be disqualified from those benefits if they receive $2,000 or more as a gift or inheritance. If you want to give your death benefit to someone receiving those government benefits, work with an attorney to set up a special needs trust and name that trust as your beneficiary.

6. Save your loved ones time and money

Keep in mind that if you name your estate as your beneficiary, or if you list a beneficiary who's not living, your loved ones will likely spend valuable time collecting required documents and their own money on attorney and court fees.

Note: Products issued and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company. Not available in all states or may vary by state. In all situations, the policy is the governing document and AUL pays benefits in accordance with policy provisions. Provided content is for overview and informational purposes only and is not intended as tax, legal, fiduciary, or investment advice.

To choose your beneficiary, visit the Forms section on **employeebenefits.aul.com**, click on the Life tab, download and complete the beneficiary designation form, and turn it into your employer.

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Sample beneficiary designations

The beneficiary wording should be absolutely clear and without question as to whom the proceeds are to be paid. Listed below are sample beneficiary designations. Please note state laws may prohibit naming certain entities and individuals as a beneficiary. If you live in a community property state, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI.

To ensure the correct individual or entity receives the benefits and the intended benefit amount, please provide the following:

- The beneficiary's Social Security number or Tax Identification number and date of birth.
- Distribution of proceeds should be shown in fractions or percentages if multiple beneficiaries are designated, and should add up to 1 if using fractions or 100% if using percents. Do not list dollar amounts as the amount of the insured's life benefit may change. If no distribution is shown, benefits will be divided equally among the living beneficiaries.

Acceptable beneficiary designations

1. One Beneficiary - State the full name and relationship to the insured. Sample: John Doe, husband
2. Two Beneficiaries in Equal Shares. Sample: Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
3. Three or More Beneficiaries in Equal Shares. Sample: Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
4. Two Beneficiaries in Succession - If the primary beneficiary dies, the second person named will receive the proceeds and is known as the contingent beneficiary. Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin.
5. Three or More Beneficiaries in succession - If the primary and secondary beneficiaries die, the third person named will receive the proceeds. Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin, or, in the event of his death, Jane Doe, niece.
6. One Beneficiary Followed by Two Beneficiaries in Equal Shares. Sample: Martha Doe, wife, or, in the event of her death, Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
7. One Beneficiary Followed by Three or More Beneficiaries in Equal Shares. Sample: John Doe, husband, or, in the event of his death, Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
8. Two Beneficiaries Shown in Percentages. Sample: John Smith, cousin 40%, Sally Smith, aunt 60%.
9. Two or More Beneficiaries Shown in Percentages. Sample: Mary Doe, wife 50%, Jane Doe, cousin 25%, John Doe, cousin 25%.
10. Estate Do not identify the name of the executor or executrix since this name may change as wills are updated. Sample: Estate of John Doe
11. Custodian for Minor Children - Please note any minor child beneficiary designation should nominate a custodian (i.e. bank, adult, trustee followed by the words "as custodian for (minor child's name) under the (child's residential state) uniform transfers to minors act." This designation may avoid a court appointed guardianship for the payment of the death benefit. Sample: John Doe as custodian for Jimmy Smith under the Indiana Uniform Transfers to Minors act.
12. Trust Agreement - State the name of the trust and the date of the trust agreement. Sample: John Doe Trust dated MM/DD/YY. Payment to trustee shall discharge the company.
13. Wife or Unnamed Children. Sample: Martha Doe, wife, or, in the event of her death, our children, if any, or their survivors.
14. Unnamed Children. Sample: Children, if any, in equal shares, or their survivors.
15. No Relationship. Sample: Mary Doe, friend
16. To a Church or Organization - It is preferable to indicate both the name and address and the wording "or its successors or assigns." Sample: Christ Lutheran Church or its successors or assigns
17. Irrevocable Beneficiary - This is acceptable, but not preferable, as the beneficiary must then approve any future beneficiary change. Sample: John Smith, husband, irrevocable beneficiary
18. Employee Unable to Sign - This designation must contain the person's mark and be signed by two disinterested witnesses.

Unacceptable beneficiary designations

- Collateral assignments, e.g. to banks, finance companies, etc. as creditors on a loan.
- The Employer
- Funeral Homes

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Linda Eldridge, Payroll Co.
Address	1702 School Street
City, State	Freedom, PA 15042
Telephone	724-775-7644
E Mail	leldridge@freedomareaschools.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

- DATE OF NOTICE: August 9, 2022
- CONTACT: Linda Eldridge, leldridge@freedomarea.org, 724-775-7644