2014

Summary Plan Description
for the
Prescription Drug Program

Administered by CVS Caremark

For Benefits Effective January 1, 2014
The Prescription Drug Program

The prescription drug program, administered by CVS Caremark, offers a retail and mail order feature. That means when filling a prescription you have the following options:

- Retail Pharmacy - for short term (30-day supply) medications
- Mail Order or CVS Retail Pharmacy – for maintenance medications up to a 90-day supply.
- Specialty Home Delivery – for specialty drugs limited to a 30 day supply

Participating in the Prescription Drug Plan
The prescription drug plan is a separate and distinct program and is not part of any of the medical options available to you. If however, you elect to participate in a medical plan, you and your covered dependents automatically participate in the prescription drug program.

When Coverage Begins
Your prescription drug coverage becomes effective when your medical coverage becomes effective. If you are disabled and away from work on the date your coverage should begin, contact the plan administrator about the effective date of your coverage.

If you have enrolled your dependents for medical and prescription drug coverage, their coverage begins on the day that you are eligible for coverage. If you don’t enroll dependents when first eligible, you must wait until the next open enrollment period—unless you have a qualifying change in family status.

When Coverage Ends
Coverage under the prescription drug program ends:

- when you are no longer an eligible employee
- when the plan ends
- when you fail to make any required contributions
- Please see your HR Department for specific term rules

Coverage for your dependents ends when:

- your coverage ends
- you fail to make any required contributions
- a dependent is no longer an “eligible dependent” (see Eligibility section in your Medical Summary Plan Description for definition of eligible dependent)

Categories of Prescription Drugs
The amount you pay for a prescription drug is determined by where and how you fill the prescription and what type of drug you purchase. The three categories of drugs include the following:
**Generic Drugs** – A generic drug contains the same active ingredients and is identical in dose, form and administrative method as a brand name; however, the generic is no longer protected by a patent. It costs less, since its manufacturer does not have to pay to develop or market the drug. This savings is passed on to you in the form of lower copayments for generic drugs.

**Preferred Brand-Name Drugs** – These are prescription drugs that have no generic equivalent and are listed as “preferred prescription drugs” due to their clinical effectiveness. These drugs have a higher copayment than for generic drugs.

**Non-Preferred Brand-Name Drugs** – These are prescription drugs that are not listed as “preferred prescription drugs.” These drugs may be newer to the market and are priced higher than the listed brand-name drugs. You will pay the highest copayment amount for this category of drugs.

To be covered, drugs must be prescribed by a physician and, when obtained from a retail pharmacy, dispensed by a licensed pharmacist.

When available and appropriate, your prescription will be filled with a generic equivalent. If a brand medication is dispensed when a generic is available, you will pay the generic copay plus the difference in cost between the brand and the generic. When visiting your doctor, it makes sense to discuss whether generic or brand-name drugs are most appropriate for your therapy.

**Finding a Network Pharmacy**
Many pharmacies nationwide participate in the prescription drug program. Your pharmacist can tell you if your pharmacy participates or you can call CVS Caremark at 1-888-850-8130. Our AdvanceRx.com website also provides an interactive retail pharmacy locator, complete with directions and maps. Members can find pharmacies that meet specific criteria, such as, 24-hour pharmacies, those within their zip codes or those within a 5-mile radius of their home.

**If You Don’t Show Your Card**
When you fail to show your prescription drug card, you pay the full cost of the prescription and then file a claim form for reimbursement. You receive reimbursement in an amount equal to the “reasonable and customary” cost of the drug minus the copayment you would have paid if you had used a network pharmacy.

If you return back to your pharmacy within 10 days of the day you paid full cost, you can have the pharmacy rerun the prescription using the Caremark card for a full reimbursement.

The steps you should take to file a claim when you use an out-of-network pharmacy include the following:

- Call CVS Caremark at 1-888-850-8130 to request a claim form;
- Complete the claim form;
- Attach a copy of your receipt for the drugs to the claim form; and
- Mail to: CVS Caremark  
  P.O. Box 52116  
  Phoenix, AZ 85072-2116
Using the Mail Service Program or CVS Retail Pharmacy for your Maintenance Medications

You have two options for filling your long-term* medications. You have the choice of:

- Getting your 90-day supply of long-term medication through the CVS Caremark Mail Service pharmacy
- Picking up your 90-day supply at a CVS Retail Pharmacy

Note: All maintenance medications must be ordered through Caremark’s mail order service or at a CVS Retail Pharmacy. You’ll be allowed one initial (30-day) fill and two (30-day) refills of maintenance medications at a retail pharmacy. After that, all refills must be processed through mail order or at a CVS Retail Pharmacy. Your doctor will need to fill out a new prescription for a 90-day initial fill and 3 (90-day) refills if the medication is to be taken for a full year. If you need to start on a maintenance medication right away, ask your doctor for both a 30-day and a 90-day prescription.

*A long-term medication is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol.

Here are the steps for receiving your maintenance medication through a CVS Retail Pharmacy:

1. Request a prescription for a 90 days supply (plus three refills)
2. Present your prescription at any CVS Retail Pharmacy and your medication will be dispensed for you.

Here are the steps to take to fill a prescription through the mail order service:

1. Be sure the prescription provides all of the following information:
   - Patient’s full first and last name;
   - Doctor’s name;
   - Exact strength, quantity, and dosage; and
   - Written for a 90-days supply plus three refills

2. Complete a patient profile/order form and enclose your original prescription(s), along with payment for each prescription.

3. Send your completed order to:

   CVS Caremark
   P.O. Box 94467
   Palatine, IL 60094-4467
Your prescription will be delivered to your home by first class mail. For delivery by first class mail, allow at least seven to ten days from the time you file your prescription order for receipt of your medication. Expedited delivery via Federal Express is available at an additional charge to you.

If you are required to take any medication for more than one year, you must file a new prescription mail order form each year—even if you have not had the maximum number of refills. In addition, other state or governmental requirements may affect the frequency of providing new prescriptions for certain medications.

**Refills Under the Mail Order Program**

There are four ways you can refill your mail order prescriptions:

- Call 1-888-850-8130, or
- Log on to [www.caremark.com](http://www.caremark.com)
  All you need is your prescription number, zip code and credit card information, or
- Mail in your request for refill(s). (Please do not send cash in the mail.)
- Automatic Refill – by phone or on-line request

**Note: Telephone and online orders are processed and delivered faster.**

Orders from CVS Caremark are sent in plain, tamper-evident packaging for security and confidentiality. Orders are shipped by First-class U.S. Mail. You may request next day or second day delivery for an additional charge.

**Covered Expenses**

Most prescription drugs, which are FDA-approved and prescribed to treat an illness or injury, are covered. A licensed physician must write prescriptions on a prescription form; prescriptions not written on prescription forms will not be considered.

Prescription drugs covered under this plan include drugs that:

- Bear the legend “Caution: Federal Law prohibits dispensing without a prescription”;
- Are a compound medication of which at least one ingredient is a prescription drug;
- Require a prescription by a physician to dispense and that are approved by the U.S. Food and Drug Administration for general use in treating the sickness or injury for which they are prescribed;
- May be dispensed under authorization by a physician under any state law;
- Includes injectable insulin, which does not require a prescription under many state laws; and
- Are purchased from a physician, dentist or any other person or organization licensed to dispense drugs.
- Diabetic care: Blood glucose monitors, disposable blood/urine glucose/acetone testing agents, disposable insulin needles/syringes, insulin, insulin delivery devices (e.g. BD Pen, NovolinPen and NovoPen), lancets and lancet devices.
High Performance Generic Step Therapy
Please refer to your plan summary to see if this program applies to your plan
Before certain brand-name drugs are covered, it is necessary to try a generic drug first. If you continue using the brand-name drug before having tried a generic medication, your prescription may not be covered and you may need to pay the full cost. Targeted therapeutic classes and specific drug targets are subject to change based on new generic drug launches, product approvals, drug withdrawals, and other market changes. Your doctor may request the use of a preferred and non-preferred brand drug without first prescribing a generic when it is required for medical necessity.

Please contact the CVS Caremark Prior Authorization Department toll-free at 1-877-203-0003 to answer criteria questions to determine coverage.

Specialty Preferred Drug Program
Please refer to your plan summary to see if this program applies to your plan
The Specialty Preferred Drug Plan Design (SPDPD) steers utilization to the lowest-cost preferred drugs in a specific biologic class while offering appropriate, safe choices for patients and their physicians. Step therapy encourages the use of the preferred drug rather than the immediate utilization of a non-preferred drug. In an SPDPD an established evidence-based protocol must be met before a non-preferred specialty drug will be covered. Simply put, a step therapy preferred drug strategy enhances the use of safe, equally effective and less expensive drugs before "stepping up" to a more expensive therapeutic alternative.

Specialty Guideline Management Program
Please refer to your plan summary to see if this program applies to your plan
The specialty pharmacy program is for specialty pharmacy medications which are designated as “self administered.” These are medications which are administered outside of the physician’s office – and may either be injectable/or oral medications. There are also several infused medications – (usually in the hemophilia class) and oral cancer medications. The specialty medications are typically used to treat ongoing conditions such as rheumatoid arthritis, multiple sclerosis, cancer, HIV, and transplants. If you are starting a specialty drug for the first time or have questions whether your prescription is a specialty medication, contact the Caremark Specialty Pharmacy at 1-800-237-2767. All specialty medications must be approved by the CVS Caremark Specialty Pharmacy Program. CVS Caremark will work with your doctor to review your medicine and treatment plan and decide whether they meet drug-specific guidelines.

Prescriptions for specialty pharmacy medications must be filled through a CVS Caremark Specialty Pharmacy. Coverage is limited to a 30-day supply.

Prior Authorization and Quantity Limits
Prior Authorizations
Prior Authorization is the process of obtaining pre-approval of coverage for certain prescription medications prior to dispensing. If your medication is included on the Prior Authorization list, your physician should call 1-888-413-2723 to request Prior Authorization for you. There are preset Prior Authorization Clinical Guidelines which must be met for approval. The following steps will need to be taken in order to obtain a Prior Authorization:

- Your physician must call CVS Caremark at 1-888-413-2723 to obtain a Prior Authorization form. The form will be faxed to your physician’s office.
- Once completed and faxed back to CVS Caremark, the information provided by your physician will be evaluated by a team of pharmacists and pharmacy technicians.
• If the Prior Authorization clinical guidelines are met, your Prior Authorization will be approved and entered into the system.
• If the clinical guidelines are **not** met, your physician will be sent a denial form.
• If the prior authorization is denied, you can still get your prescription but you will be financially responsible for the full charge of the prescription.
• Your physician can appeal the denial. The instructions to appeal the denied Prior Authorization Request are included with the denial form.

The following list includes categories (with medication examples) that require Prior Authorization. *This list is subject to revision.*

<table>
<thead>
<tr>
<th>Antifungals</th>
<th>Diabetic Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lamisil</td>
<td>• Regranex</td>
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<tr>
<td>• Sporanox</td>
<td></td>
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<table>
<thead>
<tr>
<th>Topical Acne (PA required if older than 35)</th>
<th>Anabolic Steroids</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Atralin</td>
<td>• Anadrol-50</td>
</tr>
<tr>
<td>• Avita</td>
<td>• Oxandrin</td>
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<tr>
<td>• Differin</td>
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<tr>
<td>• Retin-A</td>
<td></td>
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<tr>
<td>• Retin-A micro</td>
<td></td>
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<tr>
<td>• Trein-X</td>
<td></td>
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<tr>
<td>• Tretinoin</td>
<td></td>
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<tr>
<td>• Tazorac (for all ages)</td>
<td></td>
</tr>
<tr>
<td>• Ziana</td>
<td></td>
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<tr>
<td>• Veltin</td>
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<table>
<thead>
<tr>
<th>ADD / Narcolepsy (PA required if older than 18)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Adderall</td>
<td></td>
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<tr>
<td>• Adderall XR</td>
<td></td>
</tr>
<tr>
<td>• Concerta</td>
<td></td>
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<tr>
<td>• Desoxyn</td>
<td></td>
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<tr>
<td>• Dexedrine</td>
<td></td>
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<tr>
<td>• Focalin</td>
<td></td>
</tr>
<tr>
<td>• LiQuadd/ProCentra</td>
<td></td>
</tr>
<tr>
<td>• Metadate CD</td>
<td></td>
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<tr>
<td>• Metadate ER</td>
<td></td>
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<tr>
<td>• Methylin</td>
<td></td>
</tr>
<tr>
<td>• Methylin ER</td>
<td></td>
</tr>
<tr>
<td>• Nuvigil</td>
<td></td>
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<tr>
<td>• Provigil</td>
<td></td>
</tr>
<tr>
<td>• Ritalin</td>
<td></td>
</tr>
<tr>
<td>• Strattera</td>
<td></td>
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<tr>
<td>• Vyvanse</td>
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**Quantity Limits**

The following list indicates which medications are included in the Quantity Limits program. The quantities allowed per each fill are based upon the dosing recommendations made by the manufacturer and are reviewed by a committee of physicians and pharmacists. Prior authorization based on medical necessity is required to dispense medications in excess of the Influenza Migraine limits listed below.
<table>
<thead>
<tr>
<th>Drug</th>
<th>RETAIL</th>
<th>MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Erectile Dysfunction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caverject</td>
<td>6 units every 25 days*</td>
<td>18 units every 75 days*</td>
</tr>
<tr>
<td>Edex</td>
<td>6 units every 25 days</td>
<td>18 units every 75 days</td>
</tr>
<tr>
<td>Muse</td>
<td>6 units every 25 days</td>
<td>18 units every 75 days</td>
</tr>
<tr>
<td>Viagra</td>
<td>6 units every 25 days</td>
<td>18 units every 75 days</td>
</tr>
<tr>
<td>Cialis</td>
<td>6 units every 25 days</td>
<td>18 units every 75 days</td>
</tr>
<tr>
<td>Levitra</td>
<td>6 units every 25 days</td>
<td>18 units every 75 days</td>
</tr>
<tr>
<td>Staxyn</td>
<td>6 units every 25 days</td>
<td>18 units every 75 days</td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relenza</td>
<td>40 caps every 180 days</td>
<td>Not available through mail</td>
</tr>
<tr>
<td>Tamiflu capsules</td>
<td>14 to 28 caps every 180 days</td>
<td>Not available through mail</td>
</tr>
<tr>
<td>Tamiflu susp.</td>
<td>180 ml every 180 days</td>
<td>Not available through mail</td>
</tr>
<tr>
<td><strong>Migraine</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amerge</td>
<td>9 tablets every 25 days</td>
<td>27 tablets every 75 days</td>
</tr>
<tr>
<td>Axert</td>
<td>12 tabs every 25 days</td>
<td>36 tabs every 75 days</td>
</tr>
<tr>
<td>Frova</td>
<td>9 tablets every 25 days</td>
<td>27 tablets every 75 days</td>
</tr>
<tr>
<td>Imitrex tabs</td>
<td>9 tabs every 25 days</td>
<td>27 tabs every 75 days</td>
</tr>
<tr>
<td>Imitrex Inj Kits</td>
<td>8 kits every 25 days</td>
<td>24 kits every 75 days</td>
</tr>
<tr>
<td>Imitrex Inj vials</td>
<td>10 vials in 25 days</td>
<td>30 vials every 75 days</td>
</tr>
<tr>
<td>Imitrex NS</td>
<td>12 units every 25 days</td>
<td>36 units every 75 days</td>
</tr>
<tr>
<td>Migranal</td>
<td>8 ml every 25 days</td>
<td>24 ml every 75 days</td>
</tr>
<tr>
<td>Maxalt</td>
<td>12 tabs every 25 days</td>
<td>36 tabs every 75 days</td>
</tr>
<tr>
<td>Maxalt MLT</td>
<td>12 tabs every 25 days</td>
<td>36 tabs every 75 days</td>
</tr>
<tr>
<td>Relpax</td>
<td>12 tabs every 25 days</td>
<td>36 tabs every 75 days</td>
</tr>
<tr>
<td>Treximet</td>
<td>9 tabs every 25 days</td>
<td>27 tabs every 75 days</td>
</tr>
<tr>
<td>Sumavale DosePro</td>
<td>12 units every 25 days</td>
<td>36 units every 75 days</td>
</tr>
<tr>
<td>Zomig 2.5mg and Zomig ZMT</td>
<td>12 tabs every 25 days</td>
<td>36 tabs every 75 days</td>
</tr>
<tr>
<td>Zomig 5mg</td>
<td>12 tabs every 25 days</td>
<td>36 tabs every 75 days</td>
</tr>
<tr>
<td>Zomig NS</td>
<td>12 units every 25 days</td>
<td>36 units every 75 days</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stadol NS</td>
<td>6 ml every 25 days</td>
<td>18 ml every 75 days</td>
</tr>
<tr>
<td>Toradol</td>
<td>20 tabs every 25 days</td>
<td>Not available through mail</td>
</tr>
</tbody>
</table>

*Note: The 25- and 75-days indicate release dates for refills for 30- and 90-day supplies.

If you have questions about these or any other drugs, please don’t hesitate to call CVS Caremark Member Services at 1-888-850-8130.

**Exclusions**

Although most types of prescription drugs are covered, there are some drugs that are not covered or have limited coverage. The following is a summary of drugs that are not covered under the prescription drug provisions of the plan:

- Drugs that are deemed experimental in terms of generally accepted medical standards;
- Charges for the administration or injection of drugs or insulin;
- A quantity of drug in excess of the amounts normally prescribed by a physician or dentist (in no event more than a one-month supply or 100-unit dose, whichever is less) and a three-month supply under the maintenance drug provisions of the plan;
- A prescription refill in excess of the number specified by the physician or dentist, or any refill dispensed after one year from the date of the prescription order, except for...
continuing maintenance drugs required for active and continuing medical conditions
(the maintenance drug provisions of the plan allow three refills; however, you must
also submit a new prescription each year);

- Medication that is reimbursable under Workers’ Compensation (for any occupational
  injury or sickness or under any municipal, state or federal program; and
- Any drug or medication not listed as a covered prescription drug under “Covered
  Expenses” even if dispensed as a written or oral prescription from a physician.

- Cosmetic hair removal products.

- Immunization agents, blood or blood plasma

- Infertility medications

- Levonorgestrel (Norplant)

- Therapeutic devices or appliances unless listed as a covered product

- Medication which is to be taken by or administered to an individual, in whole or in
  part, while he or she is a patient in a hospital, rest home, sanitarium, extended care
  facility, convalescent hospital, nursing home or similar institution which operates on
  its premises, or allows to be operated on its premises, a facility for dispensing
  pharmaceuticals.

- Caremark continuously monitors the drug market which is constantly changing. New
drugs are getting FDA approval, patents are expiring and manufacturers continuously
adjust to this market with both additions and deletions to their offerings. In order to be
able to react to this ever changing landscape, the formulary needs to have the flexibility
to be adjusted quarterly. Some products are removed and others added. Products are
added that have demonstrated enhanced clinical efficacy while providing more
convenient dosage forms. Products are removed that require less convenient therapy
dosage, have more side effects and may cost more when compared to available options
on the CVS Caremark Drug List. In order to provide the best benefit to the majority of
our participants our formulary promotes less expensive and clinically appropriate
products that reaches the majority of our participants.

If you have any questions about which drugs are covered under the prescription drug program,
call CVS Caremark at 1-888-850-8130.
Important Information Regarding the Catholic Health East Employee Prescription Plan
NOTICE OF PRIVACY PRACTICE

This notice describes how confidential medical information about you and your covered family members will be protected and may be used and disclosed by the Catholic Health East Employee Prescription Plan. To learn how you can get access to this personal medical information and become familiar with your other rights and responsibilities under the law, you should review this important information carefully.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA’s notice requirement with respect to all health information created, received or maintained by the Catholic Health East Employee Prescription Plan (the Plan), sponsored by Catholic Health East (CHE).

The Plan needs to create, receive and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan’s health information privacy policy with respect to your Prescription Drug benefits. The notice tells you the way the Plan may use and disclose health information about you, describe your rights and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

Catholic Health East’s Pledge Regarding Health Information Privacy
The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as “protected health information” (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan
The Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Plan’s legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You
The following are the different ways the Plan may use and disclose your PHI:

- For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

- For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services and supplies you receive from health care providers may be paid according to the Plan’s terms. For example, the Plan may receive and maintain information about medications you received to enable the Plan to process a pharmacy’s claim for reimbursement of expenses incurred on your behalf.

- For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan’s participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to CHE in summary fashion so it can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to CHE so it may be used without CHE learning who the specific participants are.

- To Catholic Health East. The Plan may disclose PHI to designated CHE personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Plan Administrator and Human Resources staff who are directly responsible for the administration of the Plan. These individuals will protect the privacy of
your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other company employee or department and (2) will not be used by CHE for any employment-related actions and decisions or in connection with any other employee benefit plan that is not covered by the same privacy regulations.

• **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as “business associates.” For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan’s business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

• **Treatment Alternatives.** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

• **Health-Related Benefits and Services.** The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

• **Individual Involved in Your Care or Payment of Your Care.** The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition or your location. Such disclosures are always limited to the extent the friend or family member are actually involved in or directly responsible for your care, your well-being, or the payment for your care.

**As Required by Law.** The Plan will disclose your PHI when required to do so by federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.

**Special Use and Disclosure Situations**
The Plan may also use or disclose your PHI under the following circumstances:

• **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

• **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official as part of a bona fide criminal investigation or to help determine whether a crime has been committed, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime’s location or victims, or the identity, description or location of the person who committed the crime or investigation of fraud or abuse.

• **Workers’ Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers’ compensation laws and other similar programs.

• **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

• **To Avert Serious Threat to Health or Safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

• **Public Health Risks.** The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

• **Health Oversight Activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

• **Research.** Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.
• **National Security, Intelligence Activities and Protective Services.** The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

• **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

• **Coroners, Medical Examiners, and Funeral Directors.** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

**Your Rights Regarding Health Information About You**

Your rights regarding the health information the Plan maintains about you are as follows:

• **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you can request a review of the denial.

• **Right to Amend.** If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was accurate and complete, not created by the Plan, not part of the health information kept by or for the Plan, or not information that you would be permitted to inspect and copy.

• **Right to An Accounting of Disclosures.** You have the right to request an “account of disclosures.” This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment or operations; disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

• **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan’s use, disclosure or both; and (3) to whom you want the limit(s) to apply.

• **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

To request confidential communications, make your request in writing to the Plan Administrator. The Plan will attempt to accommodate reasonable requests. Your request must specify how or where you wish to be contacted.
• **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

**Changes to this Notice**
The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. A current copy of the Plan’s Notice of Privacy Practice is available in your local Human Resources office at all times.

**Complaints**
If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission occurred.

**Note:** You will not be penalized or retaliated against for filing a complaint.

**Other Uses and Disclosures of Health Information**
Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reserve any uses or disclosures already made in reliance on your prior authorization.

**Contact Information**
If you have any questions about this notice, please contact:

Privacy Office
Catholic Health East Employee Prescription Plan
3805 West Chester Pike
Suite 100
Newtown Square, PA  19073-3277

800-792-3647, x204