

Prescription Drug Plan



January 1, 2011

PLAN OUTLINE

**Lourdes Health Network
Pasco, Washington**

Prescription Drug Plan

Who Is Eligible	See Medical Plan eligibility requirements.
Service Requirement	Same as the Medical Plan criteria
Eligibility Date	Same as the Medical Plan criteria
Prior Authorization Required?	Yes
Quantity Level Limits?	Yes
Mandatory Generic Provision	Yes. If you choose to receive a formulary brand drug when a generic drug is available, your costs will be equal to the generic copayment plus the difference between the generic and the formulary brand drug.
Retail Benefit	<ul style="list-style-type: none">• Generic: 100% after \$10 copay• Formulary Brand: 100% after \$30 copay• Non-Formulary Brand: 100% after \$60 copay
Mail Order Benefit	<ul style="list-style-type: none">• Generic: 100% after \$20 copay• Formulary Brand: 100% after \$60 copay• Non-Formulary Brand: 100% after \$120 copay
Specialty Benefit	<ul style="list-style-type: none">• Generic: 100% after \$10 copay• Formulary Brand: 100% after \$30 copay• Non-Formulary Brand: 100% after \$60 copay
Pharmacy Benefit Manager (PBM)	MedImpact

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Introduction

Ascension Health and your Employer offer prescription drug benefits for you and your eligible dependents. The Ascension Health Prescription Drug Plan (the Plan) enables you to obtain prescription medications conveniently and at reasonable prices.

The information in this Summary Plan Description (SPD) is intended to serve as a summary of the Plan.

Certain words in this SPD are capitalized and defined in the Glossary in the next section. You may find it helpful to consult the Glossary as you read this SPD.

Please retain this SPD with your valuable papers. Coverage is effective only if you enroll in your Employer's medical plan and your premium has been paid.

Right to Amend or Discontinue the Plan

The Plan is based on current tax laws. Ascension Health and its participating Employers expect and intend to continue the Plan and its benefits as described in this SPD. However, Ascension Health reserves the right to amend, modify or terminate the Plan or any benefits provided under the Plan at any time and for any reason. In addition, your eligibility and participation in the Plan described in this SPD should not be construed as an employment contract.

If there are any discrepancies between the information in this SPD and the official Plan documents, the terms of the Plan documents will prevail.

Glossary

The following terms may help you in reading and understanding this SPD.

Employer Your W-2 Employer, which is an eligible participating organization of Ascension Health.

Pharmacy Benefit Manager (PBM) The person or group responsible for managing the pharmacy benefits offered by your employer. The contact information for the Pharmacy Benefit Manager is listed in Section 7, Plan and Contact Information.

Plan The group plan known as the Ascension Health Prescription Drug Plan.

Plan Outline A brief description of some of the key features of the Plan as offered by your Employer.

Section 1: Participating in the Plan

Who Is Eligible

You and your dependents are eligible to participate in the Plan if you meet the eligibility requirements described in your medical plan. If you have any questions about your eligibility, contact your Human Resources representative.

When Coverage Begins, Ends and Changes

Coverage begins, ends and changes at the same time as your medical coverage.

How to Enroll

You automatically are enrolled when you enroll in your Employer's medical plan.

Your Cost for Coverage

You and your Employer contribute toward the cost of this benefit. The amount you are required to contribute may change from time to time. The amount of required contributions will be communicated to you by your employer.

Section 2: Plan Benefits

The Plan enables you to obtain prescription drugs at a discount through participating retail pharmacies or by mail order.

Benefit Amount – Retail Pharmacy

The retail pharmacy program is for immediate drug needs or short-term prescriptions. Each time you have a prescription filled, present your Prescription Drug identification card at any participating pharmacy.

You are responsible for paying the copayment, deductible and any additional amount for brand-name drugs, if applicable. For copayment amounts and other out-of-pocket costs see the Plan Outline.

Benefit Amount – Mail-Order Program

If your health ministry participates in the mail-order pharmacy program, it is a convenient way to order up to a 90-day supply of maintenance drugs for direct delivery to your home. For copayment amounts see the Plan Outline.

Here's how the mail-order program works. Ask your physician to write your prescription for up to a 90-day supply, plus refills for up to one year. (If you need to begin the medication immediately, ask your doctor for a second prescription for a 30-day supply and have it filled at a participating pharmacy.)

Obtain a mail-order order form from the Pharmacy Benefit Manager by calling the toll-free telephone number listed in Section 7, Plan and Contact Information. You also may be able to attain a form you're your employer's intranet site or Human Resources Department. Complete the form and mail it, along with your prescription, to the mail-order pharmacy. The mail-order

pharmacy will fill your prescription and mail it to your home within two weeks. Instructions for obtaining refills – which may be ordered by telephone – will be included with your initial mail-order prescription.

You may also obtain a mail-order form or order refills online. Please see Section 7, Plan and Contact Information, for the phone number and Web site of the mail-order pharmacy.

Prescription drug copayments do not apply toward other medical plan deductibles or coinsurance limits.
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Prior Authorization

Prior authorization may be required in order for the Plan to cover certain types of drugs, such as Retin-A or Differin for participants age 34 and older; oral contraceptives (which in all cases must be medically necessary for non-contraceptive reasons); or growth hormones.

If prior authorization is required, contact Pharmacy Benefit Manager Customer Service at the toll-free telephone number shown on your identification card and listed in Section 7, Plan and Contact Information. A list of drugs that require Prior Authorization is also available on the PBM website listed in Section 7.

If the pharmacist informs you that prior authorization is required to fill your prescription, ask him or her to call the toll-free Customer Service number on your identification card for instructions.

Mandatory Generic Provision

A generic drug contains the same active ingredients and is subject to the same Food and Drug Administration (FDA) standards for quality, strength, and purity as its brand-name counterpart. Generally, a generic drug

costs less than a brand-name drug. If you choose to receive a brand-name drug when a generic drug is available, your costs will be higher. See the Plan Outline for the mandatory generic co-payment.

Narrow Therapeutic Index

Narrow therapeutic index (NTI) are drugs which can have different therapeutic effects with just a very small difference in dosage. If a patient is stabilized on a certain manufacturer's drug and switches to another manufacturer's version of the same drug, there may be a change in the therapeutic effect of that drug.

Drugs that are considered NTI by the Plan will require a brand co-pay without a penalty even if a generic is available. Please see Section 7 on how to contact the Plan Administrator for a listing of the drugs considered NTI by the Plan.

Accessing the Formulary

You may obtain information about the Formulary by contacting the Pharmacy Benefit Manager at the toll-free telephone number or Web site listed in Section 7, Plan and Contact Information.

The Formulary may also be available on your ministry's intranet site if applicable or in your local Human Resources department.

Benefit Amount – Specialty Program

If your health ministry participates in the specialty pharmacy program, it is a convenient way to order up to a 30 day supply of specialty drugs for direct delivery to your home. For copayment amounts see the Plan Outline.

Call the Specialty Pharmacy Benefit Manager listed in Section 7, Plan and Contact Information for information on filling a specialty medication.

Section 3 Other Plan Provisions

Quantity Limits

Some medications are limited by dose or by the number of units even though your physician may prescribe a higher dose or greater number of units. If the prescription has a quantity level limit, you will only be allowed to receive the quantity limit specified by the Pharmacy Benefit Manager for your copayment. To determine if a quantity limit applies to your prescription, contact Pharmacy Benefit Manager Customer Service at the toll-free telephone number shown on your identification card and listed in Section 7, Plan and Contact Information.

Step Therapy

Step Therapy helps control prescription drug costs by paying benefits for longer-established pharmaceutical therapies before newer, often costlier, treatments. The Plan may require that your doctor prescribe these “first line” medications before other drug therapies are tried. Certain other “second line” medications would be covered only after you had tried the first line therapies. Step Therapy applies only to certain medical conditions. Step Therapy approval applies to all types of prescriptions.

Contact the Pharmacy Benefit Manager for a list of medications that are subject to Step Therapy.

Half Tablet

Under the Half Tablet provision, certain medications in tablet form may be covered only for specific strengths. In general, a higher strength tablet is covered; a strength that is half that dose is not covered.

To achieve certain dosages, you will have to buy tablets that are double the dosage and

split them in half. For example, if only a 40mg dosage is covered, but you are prescribed 20mg, you will have to purchase the 40mg dosage and split each tablet into 20mg halves. This provision will apply only to medications that are easily split and that have a wide therapeutic window, that is, that are effective even if the tablets aren't split precisely in half.

Refer to the Plan Outline to see if Half Tablet coverage applies to you. If this provision applies to your location, contact the PBM for a list of medications that are subject to Half Tablet coverage.

Exclusions

Prescription drug benefits are subject to all the limitations and exclusions stated in your medical plan summary as well as the specific limitations and exclusions of the Plan and the medical plan's prescription drug component, as communicated to you from time to time. To determine if there is a limitation or exclusion on a specific prescription, contact Pharmacy Benefit Manager Customer Service at the toll-free telephone number shown on your identification card and listed in Section 7, Plan and Contact Information.

Prescriptions written by a physician who is related to you are excluded from coverage under the plan.

New drugs will be excluded from coverage for the first 180 days on the market.

Leave of Absence

If you require a leave of absence for any reason, contact your Human Resources representative. Human Resources will inform you of your Employer's leave of absence policy.

Family and Medical Leave Act of 1993

If you take a leave under the Family and Medical Leave Act of 1993, you have the option of continuing or discontinuing your prescription drug coverage along with your medical plan coverage. Consult with your Human Resources representative before taking the leave to discuss your options.

Continuation of Coverage (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents have the option of continuing medical coverage for up to 18 months at group rates if you would otherwise lose coverage because of any of the following events:

- You no longer are employed by your Employer (whether voluntarily or involuntarily, except if terminated for gross misconduct)
- You are laid off for economic reasons
- Your work hours are reduced below the minimum level necessary to be eligible for this Plan.

While termination of employment normally triggers a right to only 18 months of continuation coverage, if your employment terminates less than 18 months after you become entitled to Medicare, the continuation coverage for your eligible dependents can continue for 36 months after the date on which you become entitled to Medicare.

You and your eligible dependents will each have an independent right to elect continuation coverage. Eligible dependents can continue to be covered under the Plan for up to 36 months if they would otherwise lose coverage due to any of the following events:

- You die
- You divorce or become legally separated
- Medicare becomes your primary coverage

- The dependent no longer qualifies as an eligible child due to marriage or reaching the dependent age limit. (See your medical plan summary for the dependent age limit.)

COBRA participants are subject to the same rights and rules as those who participate in the Plan.

Extended Coverage for Disabled Individuals

An employee or covered family member who is disabled on the date of eligibility for continuation coverage or who becomes disabled within the first 60 days of the continuation coverage period may be able to extend coverage for themselves and other covered family members for up to an additional 11 months. To qualify, the Social Security Administration must officially determine that the person became disabled prior to the 61st day of the continuation coverage period. Also, that person must notify the Employer of this disability determination before the first 18 months of continuation coverage ends and within 60 days of receiving notification from Social Security that the disability determination has been made. You must send this notice to the Employer at the address shown on the Plan Outline.

If the disability ends during the 11 months of extended coverage, that person must notify the Employer within 30 days. Continuation coverage will end on the last day of the month in which the disability ended.

Cost Individuals who choose continuation coverage must pay for such coverage. They can be charged up to 102% of the cost of coverage for the type of plan and coverage they choose. For disabled people and their family members who choose to continue coverage beyond their initial 18-month eligibility period, your Employer can charge up to 150% of the cost of

coverage during the 11-month disability extension. Contributions must be paid from the date coverage otherwise would have ended.

Second Qualifying Event If you accept continuation coverage, you can experience a second qualifying event that may allow you or a family member to extend coverage further, but only up to a total of 36 months. The second qualifying event must occur while you have continuation coverage.

Example: The family of an employee who is laid off becomes eligible for continuation coverage for up to 18 months. They accept the coverage and, seven months later, the employee dies. The surviving dependents are then entitled to 36 months of continuation coverage, less the seven months of coverage they already received.

Notification The employee or family member is responsible for notifying the Employer within 60 days after a divorce or legal separation occurs or a child loses eligible status. This notice must be sent to the Employer at the address shown on the Plan Outline. Failure to provide this notice within the required timeframe will result in a loss of COBRA continuation coverage rights.

Once the Employer receives the notice, the Employer will send a continuation of coverage notice to the individual(s) in question along with a continuation of coverage form, which allows them to indicate whether they want such coverage.

Individuals must decide whether they want continued coverage within 60 days after becoming eligible or within 60 days after being notified of eligibility, whichever is later.

Termination Continuation coverage will stop before the specified time period if one of these events occurs:

- You fail to make contributions on time
- You become entitled to Medicare after you have elected COBRA continuation coverage
- The Employer stops providing a group medical plan for employees
- You become covered under another group health program after you have elected COBRA continuation coverage
- You cease to be disabled during the 11-month disability extension period.

If you become covered under another group health plan, your continuation coverage would not have to terminate early if your new plan excludes or limits coverage of preexisting conditions. Under those circumstances you could continue to receive the full benefits of your continuation coverage (not only benefits for preexisting conditions) until your original eligibility period of 18, 29 or 36 months ends or until the preexisting conditions limitation or exclusion ends, whichever occurs first.

If you have questions concerning your continuation coverage rights, you should contact the Employer at the address shown on the Plan Outline. In order to protect your family's COBRA rights, you should keep your Employer and the Plan Administrator informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices sent to the Plan Administrator or your Employer.

Section 4: Filing a Claim

When you fill your prescription at a participating retail pharmacy, no claim form is required.

If your plan allows prescriptions to be filled at a non-network pharmacy, you will need to file a claim form. Claim forms are available from the claims administrator (see Section 7, Plan and Contact Information) or your local Human Resources Department.

Determination of Benefits

The claims administrator must notify you of its benefits determination within certain time periods described below. The length of those time periods depends upon the type of claim which you submit.

For this purpose, claims are separated into four types:

Urgent Care Claims are claims for medical treatment which cannot be delayed without seriously jeopardizing your life or health, your ability to regain maximum function or, in the opinion of your doctor, would cause you severe pain. If your doctor determines that the claim involves urgent care, the Plan will determine the claim within the time period permitted for urgent care claims. If your doctor does not specify that the claim is an urgent care claim, the Plan will make that decision.

Pre-Service Claims are requests for pre-authorization or pre-certification that are not urgent care claims but that are necessary before the Plan will cover the treatment.

Post-Service Claims are requests for payment for services that have already been rendered.

Claims relating to an *ongoing course of treatment* are claims for services that will be provided (or are being provided) over a period of time or a number of treatments.

If you have a claim involving *urgent care* and you provide the required information, the claims administrator will notify you of its determination within 72 hours after receipt of the claim.

However, if your claim does not provide enough information to determine whether the Plan will cover the services, the claims administrator will notify you within 24 hours after receipt of your claim and will request specific information that is needed to complete the claim. You will have at least 48 hours to provide the information. The claims administrator will notify you of its determination within 48 hours after the earlier of:

- Receipt of the information *or*
- The end of the period allowed for providing the information.

If you or your authorized representative fail to follow the Plan's procedures for filing an urgent care claim, the claims administrator will notify you of the failure and the proper procedures for filing a claim for benefits within 24 hours following the failure. Notice may be provided orally unless you or your authorized representative request written notification.

If the Plan administrator has approved an ongoing course of treatment, the claims administrator will notify you of any reduction or termination of the course of treatment far enough in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you make a request to extend the course of treatment beyond the period of time or number of treatments and the claim is a claim involving *urgent care*, the claims administrator will decide the claim as soon as possible, taking into account the medical exigencies. The claims administrator will notify you of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim, provided that you make any such claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

In the case of a *pre-service claim*, the claims administrator will notify you of its determination within 15 days after receipt of the claim. This period may be extended one time for up to 15 days if an extension is necessary due to matters beyond the control of the Plan. If such an extension of time is taken, the claims administrator will notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You must provide the specified information within 45 days after receipt of such notice.

If you or your authorized representative fail to follow the Plan's procedures for filing a pre-service claim, the claims administrator will notify you of the failure and the proper procedures for filing a claim for benefits within five days following the failure. Notice may be provided orally, unless you or your authorized representative request written notification.

In the case of a *post-service claim*, the claims administrator will notify you of an adverse benefit determination within 30 days after receipt of the claim. This period

may be extended one time for up to 15 days if an extension is necessary due to matters beyond the control of the Plan. If such an extension of time is taken, the claims administrator will notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You must provide the specified information within 45 days after receipt of such notice.

Every notice of an adverse benefit determination will be provided in writing or electronically and will include:

- The specific reason or reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination is based
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures and the time limits applicable to such procedures
- The name of any medical or vocational expert whose advice was obtained in connection with the adverse benefit determination
- In the case of a claim involving *urgent care*, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning a claim involving *urgent care*, the notice may be provided orally, provided that a written or electronic notice is furnished not later than three days after the oral notice is provided.

You are entitled to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Appeal of Adverse Benefit Determination

If you make a request for review within 180 days after you receive notice of an adverse benefit determination, you are entitled to review of the decision by the claims administrator. You may submit written comments, documents and other information and you may receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.

The review will not afford deference to the initial adverse benefit determination. The review will be conducted by an appropriate named fiduciary of the plan who is neither the person who made the initial adverse benefit determination nor a subordinate of such person. In the case of an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual.

In the case of a claim involving *urgent care*, a request for an expedited review may be submitted orally or in writing and all necessary information, including the benefit determination on review, will be transmitted by telephone, facsimile or other available similarly expeditious method. The claims

administrator will notify you of the benefit determination on review within 72 hours after receipt of your request for review.

In the case of a *pre-service* claim, the claims administrator will notify you of the benefit determination on review within 30 days after receipt of your request for review.

In the case of a *post-service* claim, the claims administrator will notify you of the benefit determination on review within 60 days after receipt of your request for review. Notice of the decision on review will be provided in writing or electronically and will include:

- The specific reason or reasons for the adverse determination
- Reference to the specific Plan provisions on which the benefit determination is based
- A description of any available voluntary appeal procedures and information about such procedures.

You are entitled to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if you are not satisfied with the decision on review. You and the Plan administrator may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

All claims for benefits and requests for review of claim denials should be submitted to the claims administrator at the address listed in Section 7, Plan and Contact Information.

Any suit based on a denial of a claim must be filed no later than three years after the period for filing claims expires.

Coordination of Benefits Provision

The Plan does not have a coordinating provision for individuals who have more than one plan that provides prescription drug coverage. The Plan will not process payment as a secondary payer.

Subrogation and Right of Reimbursement

As a condition to receiving prescription drug benefits under this Plan, you and your dependents agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. Alternatively, if you or your covered dependent receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, you or your covered dependent agrees to reimburse the Plan in full, in first priority, for any prescription drug expenses paid by it. Regardless of whether the Plan recovers from you or another person, the Plan has an absolute right to recover all amounts it has paid (or will pay in the future) in connection with the injury or sickness without reduction for attorneys' fees or any other costs or expenses.

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including prescription expenses. Therefore, for example, the Plan can recover out of non-economic damages (such as pain and suffering) as well as economic damages (such

as medical expenses). The Plan's rights of full recovery, either by way of subrogation or rights of reimbursement, may be from funds you, a covered dependent or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, your, your covered dependents' or guardians' own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverages which are paid or payable.

The Plan may enforce its reimbursement or subrogation rights by requiring you, your covered dependent or guardian to assert a claim to any of the foregoing coverages to which he/she may be entitled. The Plan will not pay attorney fees or costs associated with a claim or lawsuit without express written authorization.

The Plan can recover amounts regardless of: (i) whether the judgment or settlement constitutes full compensation for the injury or sickness, (ii) whether the judgment or settlement is paid to you or to any other person or entity, (iii) the source of payments pursuant to the judgment or settlement, and (iv) the disposition of the payments by you or a third party.

You must notify the Plan of any claim with respect to which the Plan may have subrogation rights under the above provisions. You also are required to comply with the Plan's requests regarding preservation and enforcement of its subrogation rights. Without the Plan's written consent, neither you nor your representative may settle any claim or action with respect to which the Plan has subrogation rights. In addition, if the Plan has potential subrogation rights with respect to any injury or sickness, you and/or your attorney must sign an agreement setting forth the Plan's subrogation rights as directed and in a form approved by the Plan.

Failure to sign such an agreement will not in any way impair the Plan's subrogation rights. However, the Plan has the right to deny your claims until you provide to the Plan a signed subrogation agreement as provided above.

The Plan does not waive or release its subrogation rights by any action or inaction except by its execution and delivery of a written document expressly waiving or releasing such rights.

Misrepresentations

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud submits an application or files a claim containing a false, incomplete or misleading statement is guilty of fraud. The Plan administrator reserves the right to take appropriate action in any instance where fraud is an issue. For example, a person who commits fraud against the Plan might be excluded from future coverage and be required to repay benefits that were incorrectly paid as a result of the fraud.

Section 5: Your ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). They are described below.

Receiving Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuing Your Group Health Coverage

You have the right to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this Summary Plan Description and the documents governing the Plan for the rules that explain your COBRA continuation coverage rights.

- Have any exclusionary periods of coverage for preexisting conditions that may be required under your group health plan reduced or eliminated if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, or if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies

of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact your Human Resources representative. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 6: Group Health Plan Notice of Privacy Practices

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.

Our Responsibilities

Ascension Health takes the privacy of your health information seriously. We are required by law to maintain that privacy and to provide you with this Notice of Privacy Practices. This Notice is provided to tell you about our duties and practices with respect to your information. We are required to abide by the terms of this Notice currently in effect.

The following Plans are addressed by this notice of privacy:

-Ascension Health Prescription Drug Plan

This plan will be referenced below as the "Plan".

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category we explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- *To The Plan Sponsor.* The Plan may disclose your information to the Plan Sponsor, which is your employer, in certain situations, and may permit any

health insurance company or HMO with whom you have benefits to disclose your information to the Plan Sponsor. The plan documents that regulate the Plan must restrict how the Plan Sponsor uses and discloses your information, however.

In addition, the Plan, or its health insurance company or HMO, may disclose your "summary health information" to the Plan Sponsor to obtain premium bids from health plans for the Plan's coverage or to amend the Plan. "Summary health information" means your information that identifies you and summarizes your claims history, expenses or types, but the information will not identify you any more specifically than your zip code.

Also, the Plan, or its health insurance company or HMO, may disclose to the Plan Sponsor whether or not you are participating in the Plan or are enrolled or disenrolled from the health insurance company or HMO.

The Plan may disclose your information to the Plan Sponsor to carry out plan administration functions.

The Plan may not disclose your information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other employee benefit plan of the Plan Sponsor.

- *For Payment.* We may use and disclose your health information for the purpose of:
 - obtaining premiums or to determine or fulfill the responsibility for coverage and provision of benefits under the Plan

- coordination of benefits or the determination of cost sharing amounts;
- adjudication or subrogation of health benefit claims;
- processing claims;
- billing;
- claims management;
- collection activities;
- obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance);
- review of health care services with respect to medical necessity,
- coverage under a health plan;
- appropriateness of care, or justification of charges for the treatment and services provided to you;
- utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and
- disclosure to consumer reporting agencies of any of the following protected health information:
 - name and address;
 - date of birth;
 - social security number;
 - payment history;
 - account number; and
 - name and address of any relevant health care provider and/or health plan.

We may also provide your information to another entity for its payment activities.

We may also disclose your information to another entity for certain health care operations of that entity.

Some examples of the uses and disclosures for payment include the following. (Please note that, as is the case with the other examples in this Notice, these examples are merely a few of the many types of uses and disclosures that might be made.) The Plan will disclose your health information to the Plan's third-party administrator (TPA) so the TPA can process claims you make under the Plan. The Plan also may disclose such information to another health plan in order to determine which plan (this Plan or the other plan) should pay such claims. Health information, such as your medical history, also could be disclosed to your health care providers in order to determine whether a particular course of treatment is experimental, investigational or medically necessary.

- *For Treatment.* Unlike health care providers, the Plan does not actually provide treatment. Instead, the Plan is a mechanism to provide payment for or reimbursement of the costs of health care. Although the Plan does not actually provide treatment, it may disclose health information to physicians or other health care providers in order to enable them to treat you.

For example, disease management services may be provided through the Plan, in which case health information may be disclosed in order to enable your health care providers to deliver such services. Or, the Plan may disclose to your primary care physician the name of a specialist who is treating you so that they may coordinate your care.

- *For Health Care Operations.* We may use and disclose your health information for health care operations including:

- conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines;
 - population-based activities relating to improving health or reducing health care costs;
 - reviewing the competence or qualifications of health care professionals;
 - evaluating practitioner and provider performance, and Plan performance;
 - accreditation, certification, licensing, or credentialing activities;
 - underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss Insurance);
 - conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
 - business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
 - business management and general administrative activities of the Plan, including, but not limited to:
 - management activities relating to implementation of and compliance with the requirements of the HIPAA regulations;
 - customer service;
 - resolution of internal grievances; and
 - consistent with the applicable requirements of the HIPAA regulations, creating de-identified health information, or a limited data set.
- Examples of the foregoing include the following: The Plan may engage in activities in which the quality of care provided under the Plan is evaluated and, in doing so, may use health information or disclose such information to an organization performing the evaluation. The Plan may submit health information to an insurance company that provides “stop-loss” coverage to Ascension Health. The Plan may provide health information to auditors who review operations of the Plan in order to ensure that claims are being paid properly and that no fraud or abuse is occurring in connection with the Plan.
- *Incidental Uses and Disclosures.* We may occasionally inadvertently use or disclose your medical information when such use or disclosure is incident to another use or disclosure that is permitted or required by law. For example, while we have safeguards in place to protect against others overhearing our conversations that take place between doctors or nurses, there may be times that such conversations are in fact overheard. Please be assured, however, that we have appropriate safeguards in place to avoid such situations, and others, as much as possible.

- Disclosures to You. Upon a request by you, we may use or disclose your medical information in accordance with your request.
- Limited Data Sets. We may use or disclose certain parts of your medical information, called a "limited data set," for purposes of research, public health reasons or for our health care operations. We would disclose a limited data set only to third parties who have provided us with satisfactory assurances that they will use or disclose your medical information only for limited purposes.
- Disclosures to the Secretary of Health and Human Services. We might be required by law to disclose your medical information to the Secretary of the Department of Health and Human Services, or his/her designee, in the case of a compliance review to determine whether we are complying with privacy laws.
- De-Identified Information. We may use your medical information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law.
- As Required By Law. We will disclose your health information when required to do so by federal, state or local law.
- Marketing. The Plan may use or disclose your information to make communications to you about its products or services or benefits, as well as to describe its network or details of the Plan. If health-related products or services add value to the Plan's benefits, but are not part of it, and are available only to an enrollee of the Plan, we may use or disclose your information to describe such products or services. In addition, we may use or disclose your information for marketing if communications are made face-to-face or if they are in the form of a promotional gift of little value.
- Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Judicial Purposes. We may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- National Security and Intelligence Activities. We may release your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Protective Services for the President and Others. We may disclose your health information to authorized federal

officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- *Treatment Alternatives and Health-Related Benefits.* We may use and disclose your health information to tell you about or recommend possible health-related benefits or services that may be of interest to you.
- *Individuals Involved In Payment for Your Care.* We may release health information about you to your responsible party, friend or family member who is involved with payment for your care.
- *Third Parties.* The Plan may disclose your information to a third party that performs services on behalf of the Plan, such as its third party administrator, but only if the third party signs a contract agreeing to protect your information.
- *Disclosures of Records Containing Drug or Alcohol Abuse Information.* Because of federal law, we will not release your medical information if it contains information about drug or alcohol abuse without your written permission except in very limited situations.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures

we have already made under the authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

- *Right to Request Restrictions.* You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Vice President, Compensation & Benefits. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- *Right to Request Confidential Communications.* You have the right to request that we communicate with you or your responsible party about health matters in an alternative way or at a certain location.

To request confidential communications, you must make your request in writing to Vice President, Compensation & Benefits. You must include the reason for the request, and we will accommodate your request if the disclosure of information could endanger

you. Your request must specify how or where you wish to be contacted.

- Right to Inspect and Copy. You have the right to inspect and copy information regarding enrollment, payment, claims adjudication, and case or medical management record systems maintained by us.

To inspect and copy this information, you can submit your request in writing to Eric Feinstein, Vice President, Compensation & Benefits. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- Right to Amend. You have the right to ask us to amend your health and/or billing information for as long as the information is kept by the Plan.

To request an amendment, your request must be made in writing and submitted to Eric Feinstein, Vice President, Compensation & Benefits. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or

- Is accurate and complete

- Right to an Accounting of Disclosures You have the right to request a list of certain disclosures that we have made of your health information.

To request this list of disclosures, you must submit your request in writing to Vice President, Compensation & Benefits. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Who This Notice Applies To

This Notice describes the Plan's practices and those of all employees, staff, other Plan personnel, and the administrators contracted by the Plan to perform administrative services.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice will contain on the first page, in the

top right-hand corner, the effective date. In addition, if we revise the Notice, and you are still a participant of the Plan, then you may receive a copy of the Notice currently in effect upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person named below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about this Notice, please contact:

Vice President
Compensation & Benefits
Ascension Health
11775 Borman Drive
St. Louis, MO 63146
(314)733-8000

Section 7: Plan and Contact Information

Official Plan Name	Ascension Health Prescription Drug Plan
Employer Identification Number	31-1662309
Plan Number	512
Plan Description	Health benefit/prescription drug
Plan Sponsor and Administrator	Ascension Health 4600 Edmundson Road St. Louis, MO 63134 (314) 733-8000
Type of Administration	The Plan is jointly administered by Ascension Health and the claims administrator.
Plan Year	Plan records are administered on a calendar-year basis beginning January 1 and ending December 31 of each year.
Agent for Service of Legal Process	Ascension Health 4600 Edmundson Road St. Louis, MO 63134 (314) 733-8000
Type of Funding	You and your Employer pay the cost of this benefit.

Contact Information

The Plan has an administrative services contact with MedImpact, the Pharmacy Benefit Manger, which provides claims processing and certain other administrative services.

Pharmacy Benefit Manager	MedImpact Healthcare Systems, Inc. 10680 Treena Street San Diego, CA 92131
To Ask Questions About the Plan	MedImpact Member Services (800) 788-2949
To Access the Formulary Online	https://mp.medimpact.com/asc
To Request Prior Authorizations (Physicians only)	Telephone: (800) 788-2949 Facsimile: (858) 790-7100
To File or Appeal a Claim	MedImpact Healthcare Systems, Inc. Appeals Coordinator 10690 Treena Street 5 th Floor San Diego, CA 92131
To Obtain Medication or Refills Through the Mail-Order Program	MedVantx www.medvantxr.com 1-866-744-0621
To Obtain Medication Through the Specialty Medication Program	CoramRx (877)CoramRx or (877) 267-2679 Facsimile: (877) 513-7847 www.coramrx.com
Trustee	State Street Bank and Trust Company P.O. Box 1992 Boston, MA 02105-1992
