

## 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.**

**Effective Date: January 23, 2014**

### PURPOSE

**MedImpact Direct** is required by law to maintain the privacy of your health information in accordance with federal and state law. This Notice of Privacy Practices ("Notice") outlines our legal duties and privacy practices with respect to health information as required under the Health Insurance Portability and Accountability Act ("HIPAA"). We are required by law to provide you with a copy of this Notice and to notify you following a breach of your unsecured health information.

We will abide by the terms of the Notice. We reserve the right to make changes to this Notice as permitted by law. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Each version of the Notice will have an effective date listed on the first page. If we change this Notice, you can access the revised Notice on our website [www.medimpactdirect.com](http://www.medimpactdirect.com) or by calling **MedImpact Direct at 855- 873-8739 to request a copy be sent to you.**

### USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information without your written authorization.

**Treatment.** We may use and disclose your health information to provide you with medical treatment and services. For example, your health information may be disclosed to physicians, nurses, network pharmacies, your health plan, or other health care providers who are involved in your care to coordinate or manage your health care services or to facilitate consultations or referrals as part of your treatment.

**Payment.** We may use and disclose your health information to obtain payment for the services we provide to you. For example, we may disclose your health information to seek payment from your insurance company or from another third party. We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment or in order to determine whether your insurance company will cover the cost of the treatment.

**Health Care Operations.** We may use and disclose your health information to conduct certain of our business activities, which are called health care operations. These uses and disclosures are necessary to run our business and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing, and collection services. In these cases, we will enter into a written agreement with the business associates to ensure they protect the privacy of your health information.

**Family Members and Friends for Care and Payment and Notification.** If you verbally agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your health information. We may disclose certain health information to your family, friends, and anyone else whom you identify as involved in your health care or who helps pay for your care; the health information we disclose would be limited to the health information that is relevant to that person's involvement in your care or payment for your care. We may also make these disclosures after your death as authorized by law unless doing so is inconsistent with any prior expressed preference. We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your location, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

**Required by Law.** We may disclose your health information when required by law to do so.

**Public Health Reporting.** We may disclose your health information to public health agencies as authorized by law. For example, we may report certain communicable diseases to the state's public health department.

**Reporting Victims of Abuse or Neglect.** We may disclose health information to the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. We only make this disclosure if you agree or when we are required or authorized by law to make the disclosure.

**Health Care Oversight.** We may disclose your health information to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative, and criminal proceedings, as necessary for oversight of the health care system, government programs, and civil rights laws.

**Legal Proceedings.** We may disclose your health information in the course of certain administrative or judicial proceedings. For example, we may disclose your health information in response to a court order.

**Law Enforcement.** We may disclose your health information to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

**Deceased Persons.** We may disclose your health information to coroners, medical examiners, or funeral directors so that they can carry out their duties.

**Organ and Tissue Donation.** We may use and disclose your health information to organizations that handle procurement, transplantation, or banking of organs, eyes, or tissues.

**Research.** Under certain circumstances, we may disclose your health information to researchers who are conducting a specific research project. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

**To Avert a Serious Threat to Health or Safety.** If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information in a very limited manner to someone able to help lessen the threat.

**Specialized Government Functions.** In certain circumstances, HIPAA authorizes us to use or disclose your health information to authorized federal officials for the conduct of national security activities and other specialized government functions.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or providing for the safety of the correctional institution.

**Workers' Compensation.** We may disclose your health information as necessary to comply with laws related to workers' compensation or other similar programs.

**Please be aware that state and other federal laws may have additional requirements that we must follow or may be more restrictive than HIPAA on how we use and disclose certain of your health information. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your health information without your written permission as required by such laws. For example, we will not disclose your HIV, STD, or other communicable disease related information without obtaining your written permission, except as permitted by law. We may also be required by law to obtain your written permission to use and/or disclose your mental illness, developmental disability, or alcohol or drug abuse treatment records or your genetic test results.**

## **OTHER USES AND DISCLOSURES**

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. Some examples include:

**Marketing:** We will not use or disclose your health information for marketing purposes without your written authorization except as otherwise permitted by law.

**Sale of Your Health Information:** We will not sell your health information without your written authorization except as otherwise permitted by law.

If you change your mind after authorizing a use or disclosure of your health information, you may withdraw your permission by revoking the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your health information that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing at **MedImpact Direct**, Attention: Privacy Officer, **PO Box 51580 Phoenix, AZ 85076-1580**.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

This section describes your rights regarding the health information we maintain about you. All requests or communications to us to exercise your rights discussed below must be submitted **in writing** to **MedImpact Direct**, Attention: Privacy Officer, **PO Box 51580 Phoenix, AZ 85076-1580**.

**Right to Request Restrictions.** You have the right to request restrictions on how your health information is used or disclosed for treatment, payment, or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure of health information to your health insurance company and: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the health information pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid for in full. If we agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

**Right to Request Confidential Communications.** You have the right to request that we communicate your health information to you in a certain manner or at a certain location. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. We will not ask you the reason for your request.

**Right to Inspect and Copy.** You have the right to inspect and receive a copy of your health information. We may charge you a fee as authorized by law to meet your request. You may request access to your health information in a certain electronic form and format, if readily producible, or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit such a copy to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** You have a right to request that we amend or correct your health information that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the information be corrected. To request a correction or amendment to your health information, you must make your request in writing and provide a reason for your request. You have the right to request an amendment for as long as the information is kept by or for us. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can file a written statement of disagreement with us that will become part of your medical record.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you. Your request must state a time period which may not go back further than six years. You will not be charged for this accounting, unless you request more than one accounting per year, in which case we may charge you a reasonable cost-based fee for providing the additional accounting(s). We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

**Right to a Paper Copy of This Notice.** You have the right to receive a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. A paper copy of this Notice can be obtained by calling **MedImpact Direct at 855-873-8739** and is also available at our website at **MedImpactDirect.com**.

## COMPLAINTS

You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: **MedImpact Direct**, Attention: Privacy Officer, **PO Box 51580 Phoenix, AZ 85076-1580** or by contacting our Privacy Officer at **PrivacyS@medimpact.com**. You also have the right to complain to the Secretary of the United States Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

## CONTACT INFORMATION

If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact the **MedImpact Direct** Privacy Officer at **PrivacyS@medimpact.com**.

## ABOUT MEDIMPACT DIRECT

MedImpact Direct is an easy-to-use alternative to typical home delivery that helps you manage your medications, order your refills and have medications delivered right to your door — or wherever you need! We offer consumer-focused specialty drug delivery and mail order services for maintenance medications.

MedImpact Direct works with a high-quality network of dispensing pharmacies in the United States to fill your medications. We make sure you receive the best possible service and value from your contracted pharmacies. You may receive your prescriptions from one of our two dispensing pharmacy partners: Humana Pharmacy or NoviXus Pharmacy Services. The label on your prescription will indicate which pharmacy dispensed your medication.

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### **Acknowledgement of Receipt of Notice of Privacy Practices**

By signing below I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for MedImpact Direct. Please return to MedImpact Direct:  
**PO Box 51580 Phoenix, AZ 85076-1580**

Patient Signature: \_\_\_\_\_

Patient Name (printed): \_\_\_\_\_

Date: \_\_\_\_\_



## MEDIMPACT DIRECT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID # (if applicable): \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Address: \_\_\_\_\_

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth below:

Name and address of person or entity to whom information may be released:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for disclosure:  Request of individual  Other: \_\_\_\_\_

Specific information to be released:  Entire Prescription Record  
 Prescription Records from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

### Understandings:

- This authorization may be revoked in writing at any time, except to the extent that disclosure of information has already occurred prior to the receipt of revocation.
- If no expiration date, event or condition is noted, this authorization will expire one (1) year from the date of signing.
- This authorization may include disclosure of information relating to alcohol/drug abuse, mental health treatment, STD or HIV/AIDS related treatment only if I place my initial on the appropriate line below:  

_____ Alcohol/Drug Treatment	_____ Mental Health Treatment
_____ STD Treatment	_____ HIV/AIDS
- I understand that a photocopy of this authorization shall be considered as effective and valid as the original.
- I understand that I am signing this authorization voluntarily and that treatment, payment, health care operations, enrollment, or eligibility for benefits may not be conditioned upon my authorization of this disclosure.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

*\*If you are making this request on the behalf of another individual, evidence of authorized representative status must be provided to MedImpact Direct.*

**MedImpact Direct**

Attn: Privacy Office • PO Box 51580 • Phoenix, AZ 85076 • [PrivacyS@medimpact.com](mailto:PrivacyS@medimpact.com)  
Phone 855-873-8739 • Fax 888-783-1773

### **Discrimination is Against the Law**

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

- MedImpact Direct provides free aids and services to people with disabilities to communicate effectively with us, such as large print, audio, and accessible electronic formats.
- MedImpact Direct provides free language services through qualified interpreters to people whose primary language is not English.

If you need these services, contact MedImpact Direct Customer Service at 1-855-873-8739 (TTY dial 711), Monday through Friday from 7:00am to 7:00pm CT and Saturday 8:00am to 4:00pm CT.

If you believe that MedImpact Direct has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance:

- **By email:** 1557grievance@medimpactdirect.com
- **By mail:**  
ATTN: COMPLIANCE COORDINATOR  
MedImpact Direct  
PO Box 51580  
Phoenix, AZ 85076-1580
- **By fax:** 1-888-783-1773

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **Online:** through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- **By mail:**  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201
- **By phone:**  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available online at <http://www.hhs.gov/ocr/office/file/index.html>

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-633-7943. Someone who speaks English/Language can help you. This is a free service.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه خدمة مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-633-7943. سيقوم شخص ما يتحدث العربية مجاناً.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-633-7943。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-633-7943。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-633-7943. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-633-7943. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-633-7943. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-633-7943. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-633-7943 にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。



**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-633-7943 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Persian/ Farsi:** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرد 1-877-633-7943 فراهم می باشد.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-633-7943. Ta usługa jest bezpłatna.

**Português:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-633-7943. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-633-7943. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-633-7943. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-633-7943. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-633-7943 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.