ALLIANT
HEALTH PLANS

Member Handbook

Welcome!

We're glad you're here.

You are an Alliant Health Plans member. Our goal is for you to get the care and services that will help you make the most of your benefits. If you ever have questions, call Customer Service right away. We want you to take advantage of the best possible coverage from your plan.

We want you to know and understand how your health insurance plan works and how you can maximize the benefits your plan offers. To start with, you will find that your health insurance is unique.

Alliant Health Plans was founded by physicians and hospitals to deliver quality healthcare, not increase the bottom-line. As a Georgia nonprofit company, we invest any profits into the communities we serve through affordable health insurance plans, not paid through a payout in dividends.

Whether you are an employee or an individual member, we sincerely welcome you. Our mission is to assist you in any way possible. You won't find another health plan like Alliant.

The pages that follow are the keys to understanding your coverage and all the services you are offered. Keep this handbook as a reference point for any questions you may have about your insurance plan, member programs and requirements, or simply how to contact us.

Table of Contents

How to Reach Alliant Health Plans

Customer Service	1-800-811-4793
Website – Alliant Health Plans	AlliantPlans.com
Magellan Rx – *PharmacyBenefit Customer Care*	1-800-424-1799
24-Hour Nurse Advice Line	1-855-299-3087
Disease Management Program – *Diabetes and Asthma*	1-800-865-5922 Fax: 1-866-370-5667
Care Management Support Services	1-800-865-5922 Fax: 1-866-370-5667
Pre-Certification	1-800-865-5922 Fax: 1-866-370-5667
Alliant Health Plans Privacy Officer	1-800-664-8480 ext. 218
Report Fraud, Waste and Abuse	1-800-664-8480 ext. 218
File a Grievance or Appeal	1-800-811-4793
Personal Health Record Portal	PHR*Anywhere*.com
Expedited Appeals - *Urgent medical situations*	1-800-865-5922
Medical Appeals Address	Alliant Health Plans, Appeals Coordinator 3910 IH 35 Suite 100 Austin, TX 78704
Claim Appeals	Alliant Health Plans P.O. Box 3708 Corpus Christi, TX 78463

What is Health Insurance?

Health insurance is your protection against loss by illness or bodily injury. Health insurance provides coverage for medicine, visits to the doctor or emergency room, hospital stays and other medical expenses. Policies differ in the size of the deductible and/or co-insurance and co-payment. Health insurance can be directly purchased by an individual, or it may be provided through your employer.

Understanding How Health Insurance Works

Let's say that you are in a serious accident. You've accumulated $50,000 in covered medical expenses.

A sample health insurance plan might offer:

- Deductible: $2,000
- Coinsurance: 20 percent
- Out-of-pocket maximum: $6,000 (including your deductible amount)
    - In the example above, you would be responsible for the first $2,000 (your deductible).
    - After you pay your deductible of $2,000, you would be responsible for 20 percent coinsurance until you reach your out-of-pocket maximum of $6,000.
        - After paying your deductible, but before you reach your Out-of-pocket maximum your health insurance plan would pay covered medical expenses at the co-insurance level (in this case, 80 percent. 20 percent is paid by you).
    - After you reach your out-of-pocket maximum, you would pay nothing for any additional covered medical expenses for the rest of the plan year.

Deductible: The amount you're responsible for paying for covered medical expenses before your health insurance plan begins to pay for covered medical expenses each year.

Co-insurance: Shared costs between you and the health insurance plan. For example, you pay 20 percent of costs and your plan pays 80 percent. These percentages may be different from plan to plan. Some plans may not have coinsurance.

Co-payment: The payment you make, usually a fixed dollar amount such as $25, each time you visit the doctor or fill a prescription medication. Not all plans have co-payments. All plans sold beginning January 1, 2014 have the co-payments count towards the out-of-pocket maximum.

Out-of-pocket maximum: The most you will have to pay for covered medical expenses in a plan year through deductible and coinsurance before your insurance plan begins to pay 100 percent of covered medical expenses.

How Much Will You Pay Out of Your Pocket?

Your premium + your deductible + any co-insurance you must pay (up to your out-of-pocket maximum) + any co-payments = the most you will pay for healthcare each year (for covered services).

Once you reach the out-of-pocket maximum, insurance pays for 100 percent of your medical care (for covered services).

How you reach that out-of-pocket maximum is based on how much you pay for your medical care up front. This depends on your deductible and co-insurance percentage. The higher your deductible, the lower your monthly premiums will be, because you are willing to pay for some of your care up front.

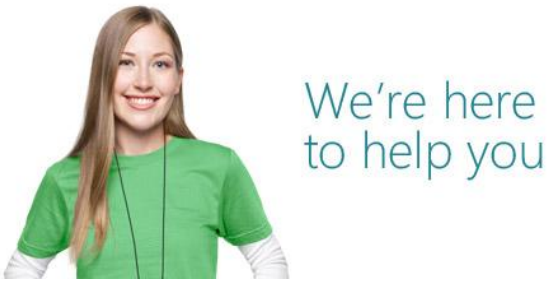
It is important to understand that premiums are costs that you pay regardless of whether you use medical services. Deductibles only become expenses once they are incurred.

Alliant Health Plans Smartphone APP

Have all of your insurance information at your fingertips with the Alliant Health Plans app for your Smartphone. No more fumbling for your insurance information; just touch the app to view your digital insurance card. Find your favorite physician – and do it with just one touch. Download the 'Alliant ID Card Mobile' today! Available for Apple and Android operating systems.

Customer Service

When you need us, we are here for you. We have customer service representatives available Monday through Friday, 8:00 am to 7:00 pm, to answer your questions.



Representatives can you help you:

- Understand your eligibility
- Understand your benefits
- Update your contact information
- Request a new ID card
- Find a doctor or hospital
- File a grievance or appeal

Customer Service can be reached at 1-800-811-4793.

Language assistance is available.

You have access 24 hours a day, 7-days a week to services through our website at AlliantPlans.com. Services include helping you to:

- Change your address or phone number
- Find a doctor
- Request a new ID card
- File a grievance or appeal

If you would like to file a claim or grievance you may write to us at:

Alliant Health Plans, Inc.
P.O. Box 3708
Corpus Christi, TX 78463

Interpreter Services

We speak your language! Interpreter and translation services are available in all languages by calling **1-800-811-4793** and selecting option **#3** at the prompt. If you or a family member needs Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at 1-800-811-4793.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción, **1-800-811-4793**.

Nurse Advice Line

You have access to health advice 24 hours a day, seven days a week through the Nurse Advice Line. A nurse is available to answer your questions about medications, symptoms, and treating non-emergency situations at home after normal business hours. You also have access to a telephonic health library. To access the Nurse Advice Line, call **1-855-299-3087**.

ID Cards

You received an Alliant Health Plans Identification (ID) Card when you received your welcome packet. Please keep this card with you at all times as it contains important information for you as well as your doctor.

You will need your ID card each time you get medical services. This means that you need your Alliant Health Plans ID card when you:

- See a doctor
- Go to an emergency room
- Go to an urgent care facility
- Go to a hospital for any reason
- Get medical supplies
- Get a prescription
- Have medical tests

Call Customer Service as soon as possible at **1-800-811-4793** or go to the Member section at **www.AlliantPlans.com** if:

- You have not received your ID card
- Information on the ID card is wrong
- You lose your ID card
- You have a baby

Your Benefits

You also received a Certificate of Coverage and Summary of Benefits & Coverage that provides details about your benefit coverage. Where appropriate this information covers co-pay amounts, deductible amounts, out-of-pocket maximums, and co-insurance responsibilities among other member-specific topics. If you would like additional copies of these documents, or have any questions about your benefits, please call Customer Service at **1-800-811-4793** or go to the Member section at **www.AlliantPlans.com**.

Access & Availability

Alliant is committed to ensuring that you have access to the right doctors when you need them. We have set up standards to make sure that you have access to enough primary care doctors and specialists to meet your health care needs. We design our doctor network to include enough primary care doctors and high volume specialists in the service area, although we sometimes have a hard time finding enough specialists in rural areas. We also make sure that you have doctors that meet your personal cultural and language needs – *i.e.* female obstetrician/gynecologists, Spanish-speaking primary care doctors. Please call Customer Service at **1-800-811-4793** if you would like help in finding a doctor in your area to meet your needs.

Your health insurance plan is a comprehensive benefit plan called a "Preferred Provider Organization" plan or PPO. This means that you have a choice between using "preferred" or "non-preferred" provider/facilities when you need medical services. In other words, you have the choice between using in-network providers/facilities that are 'participating' in the Alliant Health Plans network; or providers/facilities that 'do not participate' in our network.

Whether you choose in or out of network providers, the things your plan covers is the same (with a few exceptions) but the amount of payment by you and Alliant differs greatly. Your cost-share (the amount you pay) is much less if you use providers/facilities that are "in-network". In turn, your cost-share (the amount you pay) is much greater if you use providers/facilities that are "out-of-network".

To maximize your benefits, always use in-network providers and facilities. Each time you visit a provider/facility, you will have this choice to make. That's why it's called a " Preferred Provider Organization" plan. By the way, no referrals are needed to see a Specialist; you have direct access to in-network specialists.

To obtain a listing of doctors, hospitals and other medical service providers who are In-Network, you may complete a provider search on our web site at AlliantPlans.com or you may contact Customer Service at **1-800-811-4793** to obtain a listing.

Your Primary Care Physician

You choose a primary care physician who will be your health care partner. He or she will help you when you are sick and help you get healthy and stay well. He or she is the first doctor you see when you have health concerns. Build a relationship with your doctor. Call your primary care physician first for all your health care needs. These include routine check-ups, illness or an injury that needs prompt attention. You can talk to your doctor about any of your health concerns or medical care and services that you are receiving.

Covered Service Information

All Covered Services must be Medically Necessary. Coverage or certification of services that are not Medically Necessary may be denied. You have direct access to primary and specialty care directly from any In-Network Physician. You also may receive care from a Physician Assistant (PA) or Nurse Practitioner. For a list of In-Network providers and facilities, please visit AlliantPlans.com or call Customer Service at **1-800-811-4793**.

Pre-Certification

Some medical procedures and services require pre-certification from your doctor. To pre-certify a medical procedure or service, your doctor should call the Utilization Management Department at **1-800-865-5922**.

Emergencies do not require precertification.

All emergency admissions are reviewed within 24-hours or one working day of the admission provided the plan is contacted with the information. Once we are notified of the admission, the Utilization Management nurse coordinator immediately contacts the hospital and/or doctor to perform the admission review and begin the concurrent and discharge planning processes.

Certification approvals are given for services and other benefits based on whether the service or procedure is medically necessary. Alliant also applies other Utilization Management processes to your benefits such as concurrent and post service reviews. If you have questions about how a particular service is approved, the criteria used to make utilization management decisions, or to request information about the overall approval process, we are happy to provide you with that information. Call the Utilization Management Department at **1-800-865-5922**.

In-Patient and Out-Patient Coverage

For In-network Care, your Physician must arrange your hospital admission. Your Contract provides Covered Services when the following services are Medically Necessary.

Inpatient room charges: The length of your stay in the hospital is determined by medical necessity.

Covered Services include semiprivate room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Covered Services are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Covered Services are based on the Hospital's prevalent room rate. Pre-Certification is required for all Hospital admissions.

Services and Supplies: Services and supplies provided and billed by the Hospital while you are an Inpatient, including the use of operating, recovery and delivery rooms are covered benefits. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.

Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) are not covered.

Outpatient Services: Alliant provides Covered Services when the following outpatient services are Medically Necessary: Pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require Pre-Certification.

Care After Normal Business Hours

What do you do when you need care but your doctor's office isn't open?

If you need nonemergency care outside of normal business hours, call your doctor first. He or she may make special arrangements for you. Your doctor may send you to an urgent care center or to another provider. Remember that you always have access to our Nurse Advice Line at **1-855-299-3087.**

If it is a life-threatening emergency, you should call 911 or go to the nearest Emergency Department. For a list of facilities providing Emergency Services, please see your Provider Directory or go to www.AlliantPlans.com. If you need to speak to your doctor after hours, you can call the office directly. Even if your doctor's office is closed, the office has a doctor available 24 hours a day, 7 days a week who will let you know what to do.

Urgent Care

Urgent care centers provide services for illnesses that need to be treated within 48 hours such as the flu, high fevers or a sore throat. Other examples are ear infections, eye irritation and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

Urgent care centers are helpful if you need care quickly but can't see your primary care physician. You don't need a referral or prior authorization to go to an urgent care center. Urgent care centers are listed in the provider directory. If you go to an urgent care center, contact your primary care physician within 24 hours. He or she can arrange your follow-up care. If you aren't sure if you need urgent care, call your doctor. He or she may be able to treat you in his or her office.

Emergency Room Coverage

You are covered anywhere in the world for emergency services. You don't need a referral or prior authorization to get emergency care.

If you have an emergency and delaying your care to call your primary care physician may cause permanent damage to your health, seek care first. Go to the nearest emergency room or call 911. You may go to any emergency facility.

A medical emergency means if you don't get immediate medical attention:

- Your health, or the health of your unborn baby (if you're pregnant), may be in danger.
- Your body functions may be seriously damaged.
- Any organ or part of your body may not work properly again.

Emergency conditions may include:

- Severe pain
- Unusual chest pain
- Problems breathing
- Puncture wounds
- Nonstop bleeding
- Broken bones
- Severe bites or burns
- Blows to the head
- Sudden loss of strength or feeling in the arms or legs

Emergency services are:

- Given by a provider who is qualified
- Needed to evaluate or stabilize an emergency

Once you are in stable condition after an emergency, you may need more care to get better or fix your condition. This is called post-stabilization.

If you get emergency care, please contact your primary care physician within 24 hours. He or she can arrange your follow-up care.

Also contact Alliant Health Plans at 1-800-811-4793.

IMPORTANT: Use of the emergency room for conditions that are not Medical Emergencies is not covered.

Do not go to the Emergency Department for follow-up care. If you need help finding an in-network physician for yourself or covered family members, visit our web site at www.alliantplans.com or call Customer Service at **1-800-811-4793**.

Out-Patient Prescription Drugs

This Plan uses a Pharmacy Benefits Administrator (PBM) for the administration of out-patient prescription drug benefits. The PBM Alliant uses is called Magellan Rx. Contact information for Magellan can be found on your ID card.

Your plan requires you to use participating Magellan pharmacy. If you have questions, please call Magellan Customer Care at **1-800-424-1799.**

The Magellan pharmacy network includes local and retail pharmacies throughout the United States. The Plan will provide coverage for drugs; supplies; supplements and administration of a drug (if such services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified Provider and obtained at a participating pharmacy.

The Plan uses a Preferred Drug List, or formulary, which is a list of Prescription Drugs that are covered by the Plan. The Preferred Drug List includes drugs for a variety of disease states and Conditions. If you have questions regarding the Preferred Drug List or regarding your Outpatient Prescription Drug benefits, call the Customer Care Center for assistance, or visit our website at AlliantPlans.com to view the Preferred Drug List.

A limited number of Prescription Drugs require Pre-Authorization for Medical Necessity. If Pre-Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Pre-Authorization, please call Magellan Customer Care at **1-800-424-1799.**

MagellanRx.com for Members

Your health comes first, and MagellanRx.com can help you with your pharmacy benefit questions and more. This online tool for Members provides you with access to a wealth of information to help you better understand your prescription drug benefits, add convenience to your life and help identify cost-saving options. Whether you need to find a local pharmacy or to review your medication profile, MagellanRx.com will provide you with the information you need to take control of your personal health. You can sign in to MagellanRx.com thru Alliant's single-source log-in at PHRAnywhere.com. PHRAnywhere can also be found on our website, AlliantPlans.com.

Mental Health & Substance Abuse

Alliant recognizes that health care includes both physical and mental health services. If you need mental health and/or substance abuse services please see your provider directory or call Customer Service at 1-800-811-4793 for information about in-network services and facilities. You can also go to the provider directory online at AlliantPlans.com. For information about your mental health/substance abuse benefits, please see your Summary of Benefits and Coverage document. Please note that some benefits require pre-certification.

Utilization Management Procedures

People often have misconceptions about utilization management programs. At Alliant Health Plans all of our decisions are based on making sure you have the appropriate care and services. Our utilization management professionals have no financial incentives to deny services or to make decisions that result in under-utilization. Our UM decision-making is based only on appropriateness of care and service and existence of coverage. We want you to understand this process, and we welcome any feedback you may have. Please feel free to contact us at the number listed below.

If you call after hours, you may leave a message and a representative will return your call during regular business hours. We work with our network providers to elevate and improve delivery of health care and to improve outcomes. Our philosophy is to provide the appropriate care at the appropriate time in the appropriate setting for the appropriate length of time.

Quality Management Program

Alliant Health Plans mission is to provide high quality healthcare at an affordable price and to be stewards of the communities we serve by focusing on improving the healthcare options available to our members, participating in local and state-wide health improvement initiatives and by participation in both community and health plan outreach efforts. We believe in putting doctors in charge of treatment decisions and patients ahead of profits.

Primary goals of the Alliant Health Plans Quality Management Program:

- Continuously meet AHP's Mission, regulatory and accreditation requirements
- Ensure the delivery of high quality, appropriate, efficient, timely, and cost-effective health care and services
- Improve the overall quality of life of members through the continuous enhancement of AHP's health management programs
- Enhance quality improvement collaboration with all levels of care to include, but not limited to primary care, ob/gyn and behavioral health
- Ensure a safe continuum of care through continuity and coordination of care initiative
- Improve health promotion/disease prevention messages and programs for members through member and provider website and quarterly provider newsletters.
- Review performance against clinical practice guidelines
- Address improvements in member satisfaction through collaboration with network providers and meetings with members
- Continue to address improvements in provider satisfaction via on-site and at large meetings with providers
- Promote community wellness programs and partnering with community services

and agencies such as the North Georgia Healthcare Partnership
- Promote and facilitate the use of quality improvement techniques and tools to support organization effectiveness and decision making
- Ensure culturally competent care delivery through the provision of information, training and tools to staff and providers to support culturally competent communication

Annual Evaluation

AHP conducts an annual evaluation of the Quality Management Program in order to drive quality improvement and future programming. In 2013, AHP developed program documents and policies and procedures; identified clinical and service indicators; and redesigned the committee structure to better serve members and providers. AHP received NCQA Interim Accreditation for the Exchange products and began preparing for NCQA First Accreditation, which will occur in early 2015.

How to Save on Healthcare Costs

Most everyone is looking for ways to cut down on costs whenever they can. There are ways to save on your healthcare expenses, too. Becoming familiar with your healthcare options may help keep you and your family healthier without breaking the bank.

Choose the right level of care

When you need care, knowing your options can help save you time and money. When you choose the right level of care for your situation, it helps keep healthcare costs down and affordable for everyone.

Below are some costs options (from lowest to highest):

- **No-cost** -- **Nurse Advice line**: Call **1-855-299-3087**
- **$** -- **Doctor's office**: Offers a wide variety of services, from routine checkups to the diagnosis of a health condition.
- **$$** -- **Urgent/after-hours center**: These facilities handle many problems that can be treated in a doctor's office but are also available during non-business hours. They also offer some services not generally found in a doctor's office, such as X-rays and minor trauma rooms.
- **$$$** -- **Emergency room**: This should only be used for the most serious, life-threatening conditions, as it is the most expensive type of care.

Preauthorization Review

Utilization Management nurses review proposed surgeries and other health care services, both inpatient and outpatient. We call this our preauthorization review. If the available clinical information does not support the medical appropriateness of the requested procedure or service, clinical indications and alternative treatments are discussed with the surgeon. One of our doctor advisors may also contact the physician to discuss the treatment plan. This process has proven effective in eliminating unnecessary surgery and procedures, is less imposing on the patient, and avoids redundant examination costs.

Prospective Review

Prospective review refers to the review that takes place ***prior*** to requested procedures/admissions. This is achieved through a precertification process for elective admissions, certain diagnostic procedures, and outpatient surgeries. When participating providers are the source of the referral, it is the doctors' responsibility to notify the plan.

Prospectively reviewing requests for these services enables us to:

- To assure the efficient utilization of hospitals, physician providers, facilities, case management services, and other ancillary services.
- Continually assess and improve as necessary, member access to care and quality of the medical care available to the members.
- Educate all members, providers, and Alliant Health Plans administrative staff regarding utilization management concepts and trends of both generic and specific natures.

The majority of this activity is carried out by nurses and other utilization management professionals. They use clinical screening tools to apply consistent standards. Questionable cases are reviewed by our medical directors and a panel of doctor advisors.

Emergencies do not require precertification. All emergency admissions are reviewed within 24-hours or one working day of the admission provided the plan is contacted with the information. Once we are notified of the admission, the Utilization Management nurse coordinator immediately contacts the hospital and/or doctor to perform the admission review and begin the concurrent and discharge planning processes.

Retrospective Review

Retrospective review includes review and analysis of actual utilization data. Inpatient utilization is monitored daily, including a listing of all patients, their diagnosis, the requested length of stay versus the actual length of stay, and other information which helps us continually manage our inpatient activity. Our Quality Improvement department is involved in efforts to develop clinical guidelines, conduct outcome studies, identify unusual utilization patterns, and work with providers to alter practice patterns, as necessary.

Concurrent Review/ Discharge Planning

Concurrent review involves screening for medical necessity and the appropriateness/ timeliness of the delivery of medical care from the time of admission until discharge. The main objectives of the concurrent review process are to ensure that doctor orders are carried out in an efficient and accurate manner, to anticipate treatment, plan ahead and to continually monitor the patient's progress and facilitate discharge planning.

Discharge planning involves preparing the patient for discharge from the facility. The process includes reviewing alternate levels of care, the need for ancillary services and the potential benefits of home support.

Discharge planning is often initiated by the Utilization Management nurses before the patient is admitted to the hospital. An example is a patient being admitted for knee surgery: instead of performing crutch training in the hospital prior to discharge, we educate patients in crutch use through the outpatient physical therapy department prior to the actual admission. This provides you with an increased level of comfort and eliminates potential barriers to discharge.

Complex Case & Disease Management Programs

The Disease Management Programs focus on keeping members with certain acute or chronic conditions healthy and educating them on how to manage their own illness. Our goal is to improve the quality of care and the quality of life for these patients. Members who meet certain criteria for being at higher risk will be assessed for enrollment in one of our Complex Case Management Programs.

Current Complex Case Management Programs consist of the following:

- Diabetes
- Respiratory Disorders (Asthma)

The Disease Management Programs and Complex Case Management Programs combine the practices and technologies used by leading medical authorities with the expertise of specially trained nurse Case Managers who work directly with you and your doctors. Working closely with the your primary care doctor, Case Managers provide a variety of services, including education or regular telephone follow-ups, to ensure that you are following the plan of care properly. You learn how to better manage their own conditions, becoming active participants in maintaining good health.

Case management is the essence of managed care. Through this program we provide the appropriate medical care at the right time and in the right place. And, as we focus on improving the overall quality of health care for our members, we lower health care costs as well. To be eligible to participate in this voluntary program, you must have a doctor guiding your care, not be enrolled in any other disease case management programs, and meet certain criteria specific to each disease state. You can be referred to the program by your doctors, or may be invited to join based on our staff's review of hospital stays and claims reports.

If you have any questions, would like additional information about the complex case and disease management programs, or think you may qualify for either of these programs, please call Customer Service at **1-800-811-4793**.

Wellness Programs: Health Assessment and Self-Management Tools

In order to better help us provide you with appropriate preventive health and condition management programs, we ask you to complete an annual Health Assessment. The Health Assessment is easy to take, and asks you questions about your past and current health, lifestyle, and conditions. By answering these questions, we can provide you with better information to help you achieve your best health.

The Health Assessment is available on AlliantPlans.com through the PHR*Anywhere* member portal. You may request a paper copy of your assessment by calling Customer Service at **1-800-811-4793**.

Alliant also provides you a comprehensive set of self-management tools, available online and on paper. These tools help you learn about and manage your health conditions. By creating a secure online account, you have access to medical information, videos, self-assessments, and other tools that assist you in understanding your current situations and achieve optimal health. By participating in our wellness program you will receive information about outreach programs and other benefits. For more information, please visit our web site at AlliantPlans.com or call Customer Service at **1-800-811-4793**.

New Technology

Alliant Health Plans is committed to ensuring that your benefits cover proven medical care and technology. In order to ensure that new therapeutic and pharmaceutical technologies are reviewed and incorporated, as appropriate, into the benefit structure, Alliant has established two committees to review these new technologies on a quarterly basis. Members of the committees include physicians (in a variety of specialties), pharmacists, and other clinicians as appropriate. Following clinical recommendation, Alliant will revise its covered services to reflect new technologies. If you have any questions about this process, please call Customer Service at **1-800-811-4793**.

Extra Care for Your Good Health

We are focused on helping you get — and stay — healthy. That's why we offer a variety of services for improving your health.

Guidelines to Good Health

When it comes to risk and disease, men and women aren't very different, according to the Centers for Disease Control. The leading causes of death for men and women in the United States are heart disease, cancer, stroke and lung disease (including emphysema and chronic bronchitis).

The good news is you can reduce your health risks. The Centers for Disease Control and Alliant Health Plans recommend you:

- Eat healthy, balanced meals in moderation. Eating five or more servings of fruits and vegetables a day and less saturated fat can help improve your health. This may reduce the risk of cancer and other chronic diseases.

- Keep your weight under control. If you are overweight, you have increased risks for diseases and conditions such as diabetes, high blood pressure, heart disease and stroke.

- Exercise. Thirty minutes of moderate physical activity a day will keep you fit and help prevent disease. Exercise can be cutting the grass, dancing, swimming or just walking. The important thing is to get moving.

- Don't smoke. If you're middle-aged, smoking triples your risk of heart disease.

- Manage stress. Stress can undermine your health. If stress is causing you to eat poorly, drink too much, smoke or neglect your health, you need to take time to be good to yourself. Pay attention to your health. Make healthy living a part of your life.

- Get routine exams and screenings. This includes tests for high blood pressure, high cholesterol, diabetes, sexually transmitted diseases and prostate and colon cancer. When problems are found early, your chances for treatment and cure improve. Routine exams and screenings can help save lives.

Guidelines to Good Health for Children and Teens

Each child develops and grows on his or her own schedule. Regular well-child visits and scheduled vaccinations can keep your child on track. Talk to your doctor about what shots are right for you or your child.

The standard childhood vaccination schedule includes shots for:

- Diphtheria, tetanus and pertussis (whooping cough)
- Polio
- Measles, mumps and rubella
- Chickenpox
- Rotavirus
- Hepatitis B
- Hepatitis A
- Haemophilus influenzae type b disease, or Hib disease
- Pneumococcal disease

Both Hib and pneumococcal disease can cause pneumonia, meningitis and other serious illnesses in young children.

Teens may also need boosters and some vaccines, such as a meningitis booster or the human papillomavirus vaccine.

Guidelines to Good Health for Pregnant Women

At a minimum, low-risk women should receive the following care before, during and after pregnancy. Before you get pregnant: We want you to think of your doctor as your partner in care. Tell your doctor if you are planning to become pregnant. This discussion is very important for you and your future baby. You and your doctor can talk about health issues that might increase your risk of problems during pregnancy. These issues may include diabetes, risks in your surroundings, smoking, substance use and other health concerns.

Once you become pregnant:

- Ask your doctor about exercising during your pregnancy
- Ask your doctor about a multivitamin with iron and folic acid
- Avoid smoking and being around other people who are smoking
- Think about joining a childbirth class or parent support program
- Talk to your doctor about the benefits of breast feeding
- Don’t use alcohol or drugs without checking with your doctor

- Eat a balanced and healthy diet
- Talk to your doctor if you think you have a sexually transmitted disease
- Wear a seatbelt (lap and shoulder) in the car

Care while you are expecting: Staying healthy is important to both moms and babies. See your doctor as early as possible and keep all your appointments. Follow your doctor's directions. These visits are covered by Alliant Health Plans. It's important that moms-to-be make and keep appointments with their doctor and ask questions about their care.

Care after your baby is born: It's just as important to take care of yourself after you give birth. You should have a postpartum check-up 21 to 56 days after you deliver your baby. This exam is covered by Alliant Health Plans. The doctor may check your blood pressure and your weight. He or she may talk to you about birth control, breast feeding and provide other postpartum counseling.

Services Not Covered

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, you can still obtain treatment, but you will have to pay for it yourself. It's important that you understand while many things are covered by your plan, there are certain things that are not covered.

Your coverage does not provide benefits for:

Allergy Services - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non- specific candida sensitivity, and urine autoinjections.

Acupuncture - Acupuncture and acupuncture therapy.

Beautification Procedures - Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by Alliant.

This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous

therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within two years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

The following criteria must be met to qualify for breast reduction surgery: the affected area must be more than 250 grams over the normative average. Breast reduction surgery must meet certain criteria for coverage including a tissue removal minimum. This exclusion does not apply to Breast Reconstructive Surgery. Please see your Certificate Booklet for more information.

Before Coverage Begins - Services rendered or supplies provided before coverage begins, *i.e.*, before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.

Behavioral Disorders - Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Contract provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

Biomicroscopy - Biomicroscopy, field charting or aniseikonic investigation.

Care, Supplies, or Equipment - Care, supplies, or equipment not Medically Necessary, as determined by Alliant, for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit

air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.

Complications - Complications of non-covered procedures are not covered.

Counseling - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

Court-Ordered Services - Court-ordered services, or those required by court order as a condition of parole or probation.

Covered Services - Any item, service, supply or care not specifically listed as a Covered Service in this Certificate Booklet.

Crime - Injuries received while committing a crime as long as any injuries are not the result of a medical condition or an act of domestic violence.

Daily Room Charges - Daily room charges while the Contract is paying for an Intensive Care, cardiac care, or other special care unit.

Dental Care - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this booklet. Coverage for pediatric dental may be available based on eligibility circumstances.

Drugs - Any drug or other item which does not require a prescription.

Durable Medical Equipment - The following items related to Durable Medical Equipment are specifically ***excluded*:**

- Air conditioners, humidifiers, dehumidifiers, or purifiers;
- Arch supports and orthopedic or corrective shoes;
- Heating pads, hot water bottles, home enema equipment, or rubber gloves;
- Sterile water;
- Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate;
- Rental or purchase of equipment if you are in a facility which provides such equipment;

- Electric stair chairs or elevator chairs;
- Physical fitness, exercise, or ultraviolet/tanning equipment;
- Residential structural modification to facilitate the use of equipment;
- Other items of equipment which Alliant feels do not meet the listed criteria.

Employer-Run Care - Care given by a medical department or clinic run by your employer.

Experimental or Investigational - Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in Alliant's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

Failure to Keep a Scheduled Visit - Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.

Foot Care - Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.

Foreign Travel – Benefits do not include non-emergent care when traveling outside the United States. Benefits do include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. We cannot process a bill unless the Provider lists separately the type and cost of each service you received. All billing submitted for consideration must be translated into the English language and dollar amounts converted to the current rate of exchange.

Free Services - Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

Government Programs - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a

government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

Hair - Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.

Hearing Services - Hearing aids, hearing devices and related or routine examinations and services.

Homes - Services provided by a rest home, a home for the aged, a nursing home or any similar facility.

Hypnotherapy

Ineligible Hospital - Any services rendered or supplies provided while you are confined in an Ineligible Hospital.

Ineligible Provider - Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.

Infertility - Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof.

Injury or Illness - Care, supplies, or equipment not Medically Necessary, as determined by Alliant, for the treatment of an Injury or illness.

Inpatient Mental Health - Inpatient Hospital care for mental health conditions when the stay is:

- determined to be court-ordered, custodial, or solely for the purpose of environmental control;
- rendered in a home, halfway house, school, or domiciliary institution;
- associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situations.

Inpatient Rehabilitation - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:

- the treatment is for maintenance therapy; or
- the Participant has no restorative potential; or
- the treatment is for congenital learning or neurological disability/disorder; or
- the treatment is for communication training, educational training or vocational training.

Maximum Allowed Amount – Expenses in excess of the Maximum Allowed Amount as determined by Alliant.

Medical Reports - Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

Medicare - Services paid under Medicare or which would have been paid if the Participant had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.

Methadone - Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Contract has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.

Miscellaneous Care - Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change,

Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

Non-covered Services - Services that are not Covered Services under the Contract.

Non-Physician Care - Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers as listed in this Certificate Booklet.

Not Medically Required - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.

Obesity – Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling) and listed under Covered Services. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of

nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e.g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).

Orthoptics - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.

Outpatient Therapy or Rehabilitation - Services for outpatient therapy or rehabilitation other than those specifically listed in this Certificate Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide.

Personal Comfort Items - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

Private Room - Private room, except as specified as Covered Services.

Private Duty Nursing

Provider (Close Relative) - Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.

Routine Physical Examinations - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Certificate Booklet.

Safe Surrounding - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.

Sclerotherapy - Sclerotherapy performed for cosmetic purposes and that is not medically necessary.

Self-Help - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.

Sexual Modification/Dysfunction Treatments - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).

Shoes - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).

Skilled Nursing Facility - Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.

Telehealth - Telehealth consultations will not be reimbursable for the use of audio-only telephone, facsimile machine or electronic mail.

Thermograms - Thermograms and thermography.

Transplants - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:

- Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
- Transportation, travel or lodging expenses for non-donor family members;
- Donation related services or supplies associated with organ acquisition and procurement;
- Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
- Any transplant not specifically listed as covered.

Transportation - Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a Medical Emergency. Ambulance transportation from the Hospital to the home is not covered.

Treatment (Outside U.S.) - Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.

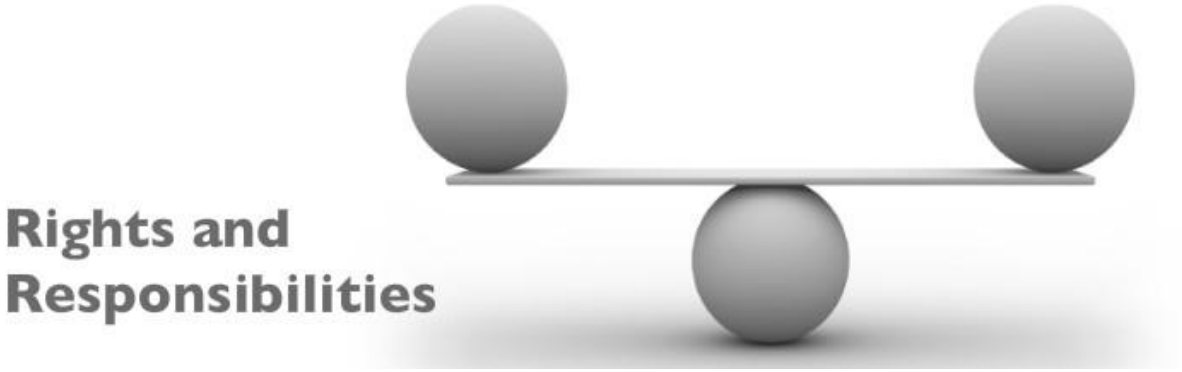
Vision - Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. This exclusion does not apply to vision for pediatric members under the age of 19.

Vision (Surgical Correction) - Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

Waived Fees - Any portion of a Provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, Alliant will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.

War - Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.

Workers' Compensation - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.



As a Member, you have the right to:

- Recommend changes to the Member's Rights and Responsibilities policy**.**
- Receive information about the Plan, its services, its Providers, and about your Rights and Responsibilities as a Member.
- Choose your Physician from the Plan's network directory listing In-Network Providers.
- Receive considerate and courteous service with respect for personal privacy and human dignity through the Plan in a timely manner.
- Expect the Plan to implement policies and procedures to ensure the confidentiality of all your personal health information.
- Understand where your consent is required and you are unable to give consent, the Plan will seek your designated guardian and/or representative to provide this consent.
- Participate in full discussion with your Provider concerning the diagnosis, appropriate or Medically Necessary treatment options, and the prognosis of your conditions, regardless of whether or not the information represents a covered treatment or benefit.
- Receive and be informed about where, when, and how to obtain all benefits to which you are entitled under your Contract including access to routine services, as well as after-hours and emergency services.
- Be informed of your Premiums, Deductibles, Copayments, and any maximum limits on Out- of-Pocket expenses for items and services.
- Receive Plan rules regarding Copayments and Pre-Certification including, but not limited to, Pre-Certification, concurrent review, post-service review, or post-payment review that could result in your being denied coverage of a specific service.
- Participate with Providers in the decision-making process concerning your health care.
- Refuse treatment and be informed by your Physician of the medical consequences.
- Receive specific information, upon your request, from Network Providers including, but not limited to, accreditation status, accessibility of translation or interpretation services, and credentials of Providers of direct care (limited to

contracted Providers). Alliant encourages Network Providers to disclose such information upon Member request.

- Receive, upon request, a summary of how Physicians, Hospitals and other Providers are compensated using a variety of methodologies, including capitation, fee-for-service, per diem, discounted charges and global reimbursement.
- Express your opinions, concerns, or complaints about the Plan and the care provided by Network Providers in a constructive manner to the appropriate people within the Plan and be given the right to register your complaints and to appeal Plan decisions.
- Receive, upon request, a summary of the number, nature and outcome of all formally filed grievances filed with the Plan in the previous three years.
- Receive timely access to medical records and health information maintained by the Plan in accordance with applicable federal and state laws.

As a Member, you have the responsibility to:

- Maintain your health and participate in the decisions concerning treatment.
- Ask questions and make certain that you understand the explanations and instructions you are given by your Physician, and comply with those conditions.
- Identify yourself as a Member when scheduling appointments or seeking specialty care, and pay any applicable Physician office Copayments at the time of service and Coinsurance or Out-of-Pocket Limits in a timely manner.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Furnish information regarding other health insurance coverage.
- Treat all In-Network Physicians and personnel respectfully and courteously as partners in good health care.
- Permit Alliant to review your medical records as part of quality management initiatives in order to comply with regulatory bodies.
- Provide, to the extent possible, information that the Plan and its Providers need in order to care for you.
- Follow the plans and instructions for care that you have agreed on with your Physician(s).

Notice of Privacy Practices

We are required by law to maintain the privacy of our members' and dependents' protected health information, provide notice of our legal duties and privacy practices with respect to protected health information and notify affected individuals of a breach of their unsecured identifiable protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. You have the right to request a paper copy of the Notice by sending your request to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

Uses and Disclosures of Your Protected Health Information Authorization. Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing our use or disclosure, including most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes and disclosures for sale of protected health information. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

A form to revoke an authorization can be obtained from the Health Information Protection Officer.

Disclosures for Treatment. We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment. We use and disclose your protected health information as necessary for payment purposes. For instance, we may use your protected health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary

care or to perform prospective reviews. We may also disclose information to another insurer in order to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We may contact your health care providers concerning prescription drug or treatment alternatives.

Genetic Information Non-discrimination Act. We are prohibited from using your genetic information for underwriting purposes. Genetic information for purposes of the underwriting means, with respect to any individual, information about (i) such individual's genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual (i.e., family medical history). It also includes the collection of genetic information for clinical research purposes, but excludes information about the sex or age of any individual.

Information Received Pre-enrollment. We may request and receive from you and your health care providers' protected health information prior to your enrollment under the group health insurance policy. We will use this information to determine whether you are eligible to enroll under the policy and to determine the premium rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverage's being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associates. Certain aspects and components of our services are performed by third party persons or organizations pursuant to agreement or contract with us. It may be necessary for us to disclose your protected health information to these third party persons or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your protected health information as required by law.

Family, Friends and Personal Representatives. With your written authorization, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information to such persons without your approval. We

may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities *(for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);*
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities *(for example, inspections, licensure actions or civil, administrative or criminal proceedings or actions);*
- For judicial or administrative proceedings *(for example, pursuant to a court order, subpoena or discovery request);*
- For law enforcement purposes *(for example, reporting wounds or injuries or for identifying suspects, witnesses or missing people);*
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces, for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation insurance purposes.

We will adhere to all applicable state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation. Except for the types of uses and disclosures of protected health information described in this Notice, we may make other uses and disclosures of protected health information only with your written authorization.

Your Rights Regarding the Restriction on Use and Disclosure of Your Protected Health Information. You have the right to request certain restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care of the paying of your health care. To request a restriction, you must send a written request to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction, except for a restriction to disclose your protected health information to a health plan if the purpose is to carry out payment or health care operations which is not otherwise required by law and the protected health information pertains solely to a health care item or service for which a person, other than the health plan, has paid the health care provider in full. If we agree to your request for a restriction, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information. You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests for such alternative means. To request a confidential communication, you must send a written request to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information. You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with a few exceptions. To request access, you must send a written request to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

A form to request access to your protected health information can be obtained from the Privacy Officer. A fee will be charged to you for copying and postage.

Amendment of Your Protected Health Information. You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information. You have the right to receive an accounting of certain disclosures of your protected health information made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee will be charged to you for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to:

Privacy Officer
Alliant Health Plans, Inc.
P.O. Box 3728
Corpus Christi, TX 78463

…or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact Customer Service at Alliant Health Plans at **1-800-811-4793**.

Non-Discrimination

Alliant Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમ ા વે થી કોઇને [એસબીએમ ક ર્યક્રમન ા ન મ મ કો] વિશે પ્રશ્નો હોય તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ા પ્ર મ કરી શક ય છે. દભ વષય્ો િ ત કરિ મ ટે,આ [અહીં દ ખલ કરો નાંબર] પર કોલ કરો(800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ወይም እርስዎ የሚያግዙትግለሰብ፣ ስለAlliant Health Plansጥያቄ ካላችሁ፣ ያለ ምንም ክፍያበቋ ንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣(800) 811-4793 ይደውሉ።

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधकिार है। ककसी भिाषए से बात करने के लिए, (800) 811-4793 पर कॉि करें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Alliant Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر شما، اي کسی که شما به وا کمک مي‌کنيد ، دروم رد لاوس Alliant Health Plans، داشته باشي حق اينا را داريد که کمک و اطلاعات به زبان خود را به طور رايگان دريافت نمايي (800) 811-4793. تماس حاصل نمايي

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がござ いましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

Notice of Non-Discrimination

Alliant Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Alliant Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Alliant Health Plans 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Alliant Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。

Alliant Health Plans લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Alliant Health Plans respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Alliant Health Plans የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Alliant Health Plans लागू होने योग्य संघीय नागरकि अधकिार क़ानून का पालन करता है और जातर्ि, रंग, राष्ट्रीय मूल, आयु, वकिलांगता, या लगि के आधार पर भेदभाव नहीं करता है।

Alliant Health Plans konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Alliant Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Alliant Health Plans يلتزم بقوانين الحقوق المدنية الفدرالية المعمول بها والتي تحظر التمييز على أساس العرق أو اللون أو الأصل الوطني أو الجنس أو الإعاقة أو السن.

Alliant Health Plans cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

Alliant Health Plans از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

Alliant Health Plans erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Alliant Health Plansは適用される連邦公民権法を遵守し、人種、肌の色、出身国、 年齢、障害または性別に基づく差別をいたしません。