SGH SafeGuard Health

SGH Plans

Agent Guide

Table of Contents

SGH Plan Overview

When it comes to our health, having flexible options allows us to live our best life. The benefits that come with SafeGuard Health can help offset the expenses members may incur on a High Deductible Health Plan (HDHP) or prior to meeting their Individual Sharing Amount (ISA) on a healthcare sharing program. With 100% coverage for Affordable Care Act (ACA) preventive services, Primary Care Physician Office Visits and a prescription drug benefit, SafeGuard Health provides supplemental benefits to help members manage the out-of-pocket costs that can quickly add up.

Plan Highlights

- Available in all 50 states
- Guaranteed Issue
- No exclusions for pre-existing conditions
- 100% Coverage for ACA mandated Preventive Services
- Low copays for Primary Care Physician visits and Specialist visits (depending on plan level)
- Prescription Drug programs to save members money on their medications
- PPO Network to help members with lower out-of-pocket costs

Eligibility Requirements

- Between the ages of eighteen (18) and sixty-four (64)
- Reside in 50 U.S. states and DC
- Dependent children must be under age twenty-six (26)

SGH plans are designed as an affordable supplement to a high deductible or healthcare sharing program. This may be the perfect option to help members save money and maximize their benefits.

SGH Plan Options

Affordable solutions that provide a range of preventive and wellness care benefits

Benefit Description	Value	Preferred	Elite
In-Network Preventive Benefits			
Coverage for Preventive Benefits under PPACA	100%	100%	100%
In-Network Services - PCP			
Primary Care Physician Visits	$35 Copay	$35 Copay	$35 Copay
Maximum Visits per covered individual per plan year	2	4	4
Maximum fee plan allows per visit	$150	$150	$150
In-Network Services - Specialist			
Specialist Physician Visits	N/A	N/A	$50 Copay
Maximum Visits per covered individual per plan year	N/A	N/A	2
Maximum fee plan allows per visit	N/A	N/A	$300
Prescription Benefits			
Tier 1 - Low Cost	Discount Card Up to 75% Discount on FDA Approved Medications	$1 Copay	$1 Copay
Tier 2 - Generics		$10 Copay	$10 Copay
Tier 3 - Preferred		$40 Copay	$40 Copay
Tier 4 - Non-Preferred		$150 Copay	$150 Copay

*The Prescription Benefit maximum amount per covered member per month on the Preferred and Elite plans is $150. After the plan meets the monthly maximum, the discount drug plan will then apply for the remainder of the month. The $150 monthly maximum amount starts over each month.

Monthly Premiums

SafeGuard Health	Value	Preferred	Elite
Primary Member	$69	$103	$147
Primary Member & Spouse	$105	$168	$209
Primary Member & Child(ren)	$89	$148	$199
Family	$119	$183	$233

This guide is a summary document. If there are any discrepancies between this guide and the Plan Document, the Plan Document terms govern.

SGH Plan Summary

When your clients choose SafeGuard Health Value they receive:

- Preventive Care Visits (including Routine Diagnostic Imaging, X-rays and Blood Work)
- Primary Care Visits (www.multiplan.com - PHCS Specific Services Network)
- Pharmacy Benefit - Discount Card (www.sghrx.com)

When your clients choose SafeGuard Health Preferred they receive:

- Preventive Care Visits (including Routine Diagnostic Imaging, X-rays and Blood Work)
- Primary Care Visits (www.multiplan.com - PHCS Specific Services Network)
- Pharmacy Benefit - 4-tier copay drug coverage (www.sghrx.com)

When your clients choose SafeGuard Health Elite they receive:

- Preventive Care Visits (including Routine Diagnostic Imaging, X-rays and Blood Work)
- Primary Care Visits plus Specialist Visits (www.multiplan.com - PHCS Specific Services Network)
- Pharmacy Benefit - 4-tier copay drug coverage (www.sghrx.com)

Additional Information

- Guaranteed Issue product
- If member exceeds their office visits, member will receive the PHCS Network discount.
- If member does not use an in-network provider, the office visit copay will not apply. The member will be responsible for the full cost of the office visit.

Prescription Benefits

CVS Caremark is a pharmacy management company that has contracted discounts at over 67,000 pharmacies nationwide, including major chains and independent pharmacies. Members can save an average of 20% on the usual and customary pharmacy retail prices on generic to brand-name drugs, with the highest percentage savings on generic drugs. It should be noted that savings will vary depending on the specific prescription drug purchased and where it is purchased.

Outpatient Prescription Drug Benefits

Value Plan - Discount Prescription Benefit

- Members save from 10% to 75% on most FDA Approved Medications
- Discounts can be used for both brand-name drugs and generics
- Members will always receive the lowest price available on their prescription purchase

Preferred and Elite Plans - 4-Tier Copay Plan

Drugs are organized by therapeutic class into 4 pricing tiers. A $150 maximum per member per month applies.*

- **Tier 1**: Low Cost - $1 Copay
- **Tier 2**: Generic - $10 Copay
- **Tier 3**: Preferred - $40 Copay
- **Tier 4**: Non-Preferred - $150 Copay

- Drugs not included on the formulary are 100% retail cost, however, members will receive the CVS discounted rate.
- Non-formulary drugs do not count toward the monthly maximum.
- 90-Day Supply Mail Order is available.

Generic Drug Facts[1]

Broad Access

Generic drugs go through a rigorous review process to receive FDA approval. The FDA ensures a generic medication provides the same clinical benefit and is as safe and effective as the brand-name medicine that it duplicates. Generic and brand-name medicine have the same active ingredients, effectiveness, quality, safety, strength and benefits.

But they can look different

Allowable differences in size, shape, and color do not impact how medications work. Generic medicines may look different than the brand-name drugs they duplicate, but they are as safe and effective.

And they can cost a lot less money

Generic medicines tend to cost less than their brand-name counterparts because they do not have to repeat animal and clinical (human) studies that were required of the brand-name medicines to demonstrate safety and effectiveness. When multiple generic companies market the same product, market competition typically results in prices about 85% less than the brand-name.

Many prescriptions have a trademark or brand name, as well as a chemical or generic name. By choosing a generic medication, members can save money without compromising quality. Members should consult with their doctor or pharmacist about lower cost options for their prescriptions.

Members can visit **www.sghrx.com** to locate participating pharmacies and access the online drug pricing tool. The drug pricing tool will assist them in anticipating potential drug costs. Members need to present their ID card at the pharmacy at the time of service. Their ID card has all the information needed to fill a prescription. If there is a problem with the pharmacist or the pharmacy network, please have the pharmacist call the Pharmacy Help Desk at **(800) 364-6331**.

If members have any questions about their prescription benefit, they can contact CVS Customer Service at **(866) 475-0056**.

*The Prescription Benefit maximum amount per covered member per month on the Preferred and Elite plans is $150. After the plan meets the monthly maximum, the discount drug plan will then apply for the remainder of the month. The $150 monthly maximum amount starts over each month.

[1] https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/genericdrugs/ucm167991.htm

PHCS Network

PHCS
Specific Services.
Call to Confirm

SGH plans include the PHCS Network through MultiPlan, Inc., which offers you:

Choice - Broad access to 5,000 hospitals, 107,000 ancillary facilities and approximately 917,000 practitioners.

Savings - Negotiated discounts that result in significant cost savings when they visit in-network providers, helping to maximize their health services. A PHCS logo on the SGH ID card tells both the Member and the Provider that a PHCS discount applies.

Quality - MultiPlan applies rigorous criteria when credentialing providers for participation in the PHCS Network, so Members can be assured they are choosing their healthcare provider from a high-quality network.

36%
Average savings on practitioner claims

35%
Average savings on ancillary claims

Find a PHCS Network Provider

Members can find participating doctors or facilities near them by going to **www.multiplan.com** and following the instructions below or by calling **(888) 263-7543**.

Home page

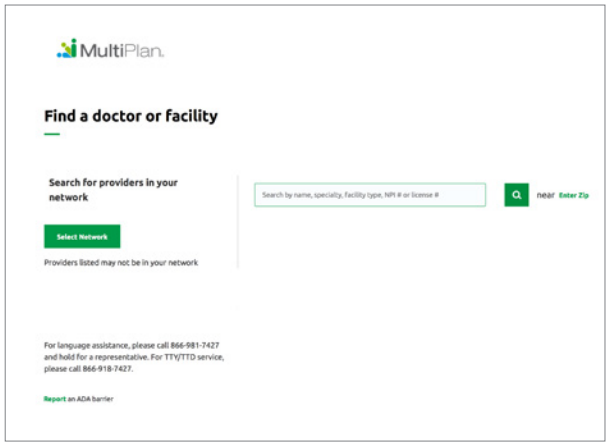
1 Click on **Find a Provider**

Find a doctor or facility page

2 Click on the Select Network button and choose PHCS

3 Click on Specific Services

4 Type in the search criteria and location



Online Provider Referral System

If Members are currently seeing a doctor or other healthcare professional who does not participate in the PHCS Network, they may use the Online Provider Referral System. On the Home page, click on **Information for Health Plan Members**, and then click on **Nominate a Provider**, which allows Members to nominate the provider in just minutes using an online form. Upon receipt of the form, MultiPlan will contact the nominee to determine whether the provider is interested in joining. If so, they will follow up to recruit the provider.

Confirm Participation in the PHCS Network

It is the Members' responsibility to confirm the provider or facility's continued participation in the PHCS Network and accessibility under the Specific Services program. When scheduling an appointment, Members need to specify that they have access to the PHCS Network, confirm the provider's current participation in the PHCS Network, their address and that they are accepting new patients. Please also be sure to follow any pre-authorization procedures required by the program (usually a telephone number on the ID card). In addition, to ensure proper handling of their bills, Members should always present their SGH ID card upon arrival at your appointment.

Please note: MultiPlan, Inc. and its subsidiaries are not insurance companies, do not pay claims and do not guarantee health benefit coverage.

Frequently Asked Questions

Q. What is SafeGuard Health (SGH)?

A. SGH is a market-based solution developed to assist individuals and families across the nation. The solution provides benefits for preventive care, copays for Primary Care and Specialist Physician visits and prescription benefits (benefits vary based on plan level selected).

Q. How does a Member check if their physician or specialist is in-network?

A. Members simply go to **www.multiplan.com** and click on "Find a provider" - see page 5 for full details about the network. Members MUST use an in-network provider to utilize the office visit copays. If members use an out-of-network provider, they will be responsible for the full cost of the visit.

Q. Does this plan cover an annual mammogram at an imaging center (not a doctor's office)?

A. SafeGuard Health will cover the screening if the claim is coded as a preventive visit. Under ACA, mammograms are covered starting at age 40. NOTE: Be sure the Doctor offices have a pre-determination, pre-authorize the procedure and confirm the procedure is coded as "preventive".

Q. Are there a lot of participating pharmacies on the SGH Rx drug plan?

A. The SGH Rx plan is accepted at over 67,000 participating pharmacies nationwide, so members are sure to find a pharmacy near them. Members simply present their ID card at the time of service to receive the discounted pricing.

Q. Where can a member check SGH Rx drug pricing and locate participating pharmacies near them?

A. Members can visit **www.sghrx.com**. The website has all the information members need to lookup and identify drugs, locate pharmacies and get directions, compare drug pricing and more.

Q. If members move to another state, will they be able to continue in their plan?

A. Yes, members will continue in their current plan if they move to another state. The plans are not available outside the U.S. and cannot be used while traveling or relocating outside the U.S.

Q. How will members identify the monthly drafts from their account?

A. All drafts will have "Premier Health Solutions" listed as the originator of the drafts.

Q. Can members cancel at any time?

A. No. This product has a 1-year agreement in which members are unable to cancel unless they have a qualified event.

Q. What is a Qualified Event?

A. A Qualified Event is one of the following:

- Change in legal marital status – marriage, divorce, annulment, death of a spouse or legal separation
- Change in dependent children – birth, adoption, legal guardianship or death of a child
- Loss of spousal coverage – loss of job, etc.
- Dependent children "age out" – child's age exceeds the age limitations of the membership

To make changes to their plan, members need to call Customer Service at **(855) 978-6927**.

Q. When a member turns 65, what happens to their policy?

A. Their policy will be termed at midnight on the day of their 65th birthday.

Q. Who do members contact if they have questions about their benefits?

A. Members can contact Customer Service at **(855) 978-6927** and one of our friendly representatives will be glad to help them! Members can also view, download and print their member materials on the Member Portal: **sghmembers.com**.

SGH Plan Covered Preventive Services

The list below summarizes some, but not all preventive services. Please reference the US Preventive Services Task Force website for the entire list: www.HealthCare.gov/center/regulations/prevention.html

In-Network Covered Preventive Services

Adults

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
4. Blood Pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults 50 to 75
7. Depression screening
8. Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965
13. HIV screening for everyone ages 15 to 65, and other ages at increased risk
14. Lung cancer screening for adults 55-80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
15. Immunizations vaccines for adults - doses, recommended ages, and recommended populations vary:
    - Diphtheria
    - Hepatitis A & B
    - Herpes Zoster
    - Human Papillomavirus (HPV)
    - Influenza (flu shot)
    - Measles
    - Meningococcal
    - Mumps
    - Pertussis
    - Pneumococcal
    - Rubella
    - Tetanus
    - Varicella (Chickenpox)
16. Obesity screening and counseling
17. Sexually transmitted infection (STI) prevention counseling for adults at higher risk
18. Statin preventive medication for adults 40 to 75 at high risk
19. Syphilis screening for adults at higher risk
20. Tobacco use screening for all adults and cessation interventions for tobacco users
21. Tuberculosis screening for certain adults without symptoms at high risk

Children

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
6. Blood screening for newborns
7. Cervical dysplasia screening for sexually active females
8. Depression screening for adolescents beginning routinely at age 12
9. Developmental screening for children under age 3
10. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish for all infants and children as soon as teeth are present
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
15. Height, weight and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
16. Hematocrit or hemoglobin screening for all children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years
19. HIV screening for adolescents at higher risk
20. Hypothyroidism screening
21. Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis (Whooping Cough)
    - Haemophilus influenza type b
    - Hepatitis A & B
    - Human Papillomavirus (HPV)
    - Inactivated Poliovirus
    - Influenza (flu shot)
    - Measles
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella (Chickenpox)
22. Iron supplements for children ages 6 to 12 months at risk for anemia
23. Lead screening for children at risk of exposure
24. Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
25. Medical history for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
26. Obesity screening and counseling
27. Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
28. Phenylketonuria (PKU) screening for newborns
29. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
30. Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
31. Vision screening for all children

In-Network Covered Preventive Services

Pregnant Women or Women Who May Become Pregnant

1. Anemia screening on a routine basis
2 Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
4. Folic acid supplements for women who may become pregnant
5. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
6. Gonorrhea screening for all women at higher risk
7. Hepatitis B screening for pregnant women at their first prenatal visit
8 Preeclampsia prevention and screening for pregnant women with high blood pressure
9. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
10. Syphilis screening
11. Expanded tobacco intervention and counseling for pregnant tobacco users
12. Urinary tract or other infection screening
13. Routine prenatal visits for pregnant women

Other Covered Preventive Services for Women

1. Breast cancer genetic test counseling (BRCA) for women at higher risk
2. Breast cancer mammography screenings every 1 to 2 years for women over 40
3. Breast cancer chemoprevention counseling for women at higher risk
4. Cervical cancer screening
   - Pap test (also called a Pap smear) every 3 years for women 21 to 65
   - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years
5. Chlamydia infection screening for younger women and other women at higher risk
6. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
7. Domestic and interpersonal violence screening and counseling for all women
8. Gonorrhea screenings for all women at higher risk
9. HIV screening and counseling for sexually active women
10. Osteoporosis screening for women over age 60 depending on risk factors
11. Rh incompatibility screening follow-up testing for women at higher risk
12. Sexually transmitted infections counseling for sexually active women
13. Syphilis screening for women at increased risk
14. Tobacco use screening and interventions
15. Urinary incontinence screening for women yearly
16. Well-woman visits to get recommended services for women under 65

SGH Plan Exclusions

Medical Exclusions

Charges for the treatment of a Diagnosed Illness or Injury are not covered under this Plan. No claims will be considered for the following:

1. Accident- Charges for the care and treatment of accident related illness or injury.
2. Ambulatory Surgical Center Services Brand Name Drugs Complications of Non-Covered Treatments- Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
3. Cosmetic Services- Charges for cosmetic services, supplies or drugs. A treatment will be considered cosmetic for either of the following reasons:

   a. Its primary purpose is to beautify; or

   b.There is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to illness, accidental injury, or congenital abnormality.
4. Court-Ordered- Charges for any court-ordered rehabilitative treatment, service, or supply.
5. Covered Medical Expenses- Charges for Covered Medical Expenses in excess of Allowable Claim Limits.
6. Date of Coverage- Charges incurred prior to the effective date of coverage, or charges incurred after the termination date of coverage.
7. Dental Services- Charges for dental work or treatment.
8. Durable Medical Equipment
9. Educational- Charges for educational or vocational services, including but not limited to schooling, books, and supplies.
10. Employment Related- Charges for treatment for an illness or injury arising out of or in the course of, employment (or self-employment) for wage or profit or gain for which the Covered Participant is reimbursed or entitled to reimbursement under any federal or state law, including worker's compensation or similar law.
11. Durable Medical Equipment Exercise- Charges for exercise or wellness programs, including physician supervised cardiac rehabilitation, occupational therapy, or physical therapy.
12. Experimental and Investigational Procedures and Treatment- Charges for Experimental and Investigational procedures or treatments and the complications resulting from those procedures or treatments are not a covered benefit under this Plan.
13. Formulary Drugs
14. Government Coverage- Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States Government for a service-related illness or injury.
15. Government Health Plan- Charges for services and supplies, which are provided by any government health plan except for state-sponsored medical assistance programs. In the case of a state-sponsored plan, any benefits will be paid to the state. Any amount paid will be considered benefits paid under the Plan and will constitute a full discharge of liability to the extent of payment.
16. Habilitative Services- Habilitation Services including physical therapy, occupational therapy and speech pathology are not covered under this Plan.
17. Home Health Services Hospice Services Hospital Admissions
18. Hospital Inpatient, Outpatient, or Emergency Services Illness- Charges for the care and treatment of a diagnosed illness, in excess of 3 office visits per Calendar Year, are not covered under this Plan.
19. Injury- Charges for the care and treatment of an accidental injury, in excess of 6 office visits per Calendar Year, are not covered under this Plan.
20. Mental/Behavioral Health- Mental/Behavioral Health and Substance Abuse Disorder Services are not covered with the exception of services listed in Schedule of Benefits as Preventive Care.
21. Non-Medical Related Examinations/Services- Charges for care, treatment, services, or supplies when performed for any of the following reasons:
    - Charges for failure to keep scheduled appointments;
    - Charges for completion of any form;
    - Charges for medical information;
    - Recreational therapy;
    - Any services or supplies that are nonmedical;
    - For purposes of obtaining, maintaining, or otherwise relating to career, sports, camp, school, travel, employment, insurance, marriage, or adoption;
    - Relating to judicial or administrative proceedings or orders;
    - Conducted for the purpose of medical research; or
    - To obtain a license of any type.
22. No Obligation to Pay- Charges incurred for which the Plan has no legal obligation to pay.
23. Non-PPO Providers- Services from Providers who are not in the Plan's Preferred Provider network are not covered.
24. Not Responsible- Charges that a Covered Participant would not be responsible for in the absence of this Plan.
25. Not Specified As Covered- Charges for services, treatments, or supplies that are not specified as covered under this Plan.
26. Organ and Tissue Transplant
27. Outpatient Surgery- Charges from a Physician or a Hospital for surgical services are not covered under this Plan.
28. Outside the US- Charges for medical expenses if the Covered Participant leaves the United States, the U.S. Territories, or Canada for the express purpose of receiving Preventive Care.
29. Physical Therapy Plan Maximums- Charges that exceed any Plan Maximum or Limitation as outlined in the Schedule of Benefits.
30. Prescription Drugs- Charges for drugs requiring written prescription are not covered by the medical portion of this Plan. Prescription drugs are provided under the prescription drug portion of the Plan. Insulin and related diabetic supplies and bee sting kits are covered under the prescription drug portion of the Plan.
31. Rehabilitative Services- Rehabilitative Services, such as physical therapy, occupational therapy, speech pathology and cardiac rehabilitation are not covered under this Plan.
32. Relationships- Charges for professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a Spouse, parent, child, brother, sister, brother-in-law, or sister-in-law, whether the relationship is by blood or exists in law.
33. Services before or after coverage- Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
34. Skilled Nursing/Extended Care Speech Therapy
35. Specialty Drugs Surgical Benefits
36. Transplants
37. Travel and/or Lodging- Charges for the cost of travel or lodging related to receiving medical treatment, except as specified under "Ambulance Services" and "Organ and Tissue Transplant" benefits under the Covered Benefits section.
38. Third-Party Liability- Any charges for which a third-party is liable, unless the Covered person who experiences such loss has agreed, in writing, to fulfill his obligations stated within the Plan Document.
39. Usual, Customary, and Reasonable Allowance- Charges in excess of the Usual, Customary, and Reasonable allowance for each service, or in excess of the maximum allowable amount.

Rx Limitations & Exclusions

Benefits are not payable for:

- Medications which do not require a prescription order, even if one is written, and medications which are not considered essential for the necessary care and treatment of an injury or sickness, or required by ACA Preventive Services.
- Medications which are not prescribed in accordance with FDA-approved uses and any medication prescribed or dispensed in a manner contrary to normal medical practices.
- Medications administered by a physician or prescriber, and those not dispensed at a pharmacy such as those you receive at your doctor's office, in a hospital, clinic or other care facility.
- Medications for which the cost is recoverable under a government program, Workers' Compensation, occupational disease law, or medications for which no charge is made to you.
- Immunization agents, allergy sera, biological sera, and charges for the administration or injection of medications, unless required by ACA Preventive Services.
- Any medication labeled "Caution - limited by Federal Law to Investigational Use" or experimental medications.
- Compounded medications of which at least one ingredient is a legend drug only at the Preferred Brand level.
- Drug classes that are excluded include injectable and intravenous drug forms, fertility, genetically engineered, growth hormones, cosmetic, smoking cessation, male sexual dysfunction, vaccines and certain diabetic supplies. Excluded generic and brand drugs are available to you under the non-covered drug portion of the program, unless required by ACA Preventive Services.
- Higher dosage strength forms of certain medications, extended release forms, kits patches and combinations products (such as compounded medications) are often excluded under the co-pay program. Same strength forms of certain medications, extended release forms, kits, patches and combination products (such as compounded medications) are often excluded from coverage under the co-pay program.
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- New to market drugs, including line extensions and new strengths until clinically reviewed.

SGH Plans

Agent Support:
(855) 978-6429
sghagentsupport@premierhsllc.com

Member Services:
(855) 978-6927
sghmembersupport@premierhsllc.com

Member Portal:
sghmembers.com

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