SGH Plan Options

SGH SafeGuard Health

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

Benefit Description	Value	Preferred	Elite
PPO Network			
PHCS Specific Services	www.multiplan.com		
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

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

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.