

2026 Provider Manual

Table of Contents

Introduction and Purpose

About the Plan

Contact Information

Provider Participation and Credentialing

Member Eligibility and Enrollment

Benefits and Covered Services

Referral and Prior Authorization Requirements

Claims Submission and Payment Policies

Quality Improvement Program

Care Management and Utilization Management

Member Rights and Responsibilities

Provider Responsibilities

Fraud, Waste, and Abuse Prevention

Compliance, Privacy, and HIPAA

Grievances, Appeals, and Dispute Resolution

Termination, Sanctions, and Corrective Actions

Pharmacy Services and Drug Formulary

Cultural Competency and Nondiscrimination

Updates and Manual Revisions

Provider Manual

Plan: HealthChoice of Michigan
TPA Services contracted to: SGRX
(Operated under the Municipal Health Facilities Corporations Act, Act 230 of 1987)
Effective Date: January 1, 2026
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1. Introduction and Purpose

This Provider Manual serves as a guide for participating providers of the HealthChoice of Michigan plan. It outlines administrative procedures, operational policies, and compliance standards. The manual supplements—but does not replace—the Provider Participation Agreement.

2. About the Plan

HealthChoice of Michigan operates under the Municipal Health Facilities Corporations Act and is directed by the Wayne County Health, Human & Services Commission. Information about the plan can be found online at https://healthchoiceofmichigan.com/

HealthChoice of Michigan contracts with SGRX, a licensed Third-Party Administrator (TPA) in the State of Michigan to perform day-to-day administrative functions on behalf of the plan. These functions include:

- Provider network management and credentialing
- Claims processing and payment
- Utilization management
- Provider relations and communication

The TPA operates under the oversight of HealthChoice of Michigan and in accordance with the Municipal Health Facilities Corporations Act (Act 230 of 1987). All participating providers are required to comply with operational procedures as outlined in this manual and as administered by the TPA.

3. Provider Contact Information

Department	Phone	Email	Fax
Provider Network Management	855.499.3232	healthchoice@sgrxhealth.com	313.264.0988
Claims & EDI Support			
Authorizations & Referrals			
Utilization Management			
Compliance & Privacy Officer			
Grievances & Appeals			

Mailing Address:

SGRX
Attn: Claims Department
PO Box 36171
Grosse Pointe Farms, MI 48236

4. Provider Participation and Credentialing

4.1 Participation Requirements

Providers must:

- Hold and maintain unrestricted licensure in Michigan.
- Maintain professional liability insurance as required by the plan.
- Comply with all state and federal program requirements (e.g., Medicaid, Medicare).

4.2 Credentialing

- Conducted prior to participation and up to every three years thereafter.
- Criteria include licensure, education, board certification, malpractice history, and exclusion checks (Michigan Sanctioned Providers List, OIG/SAM).

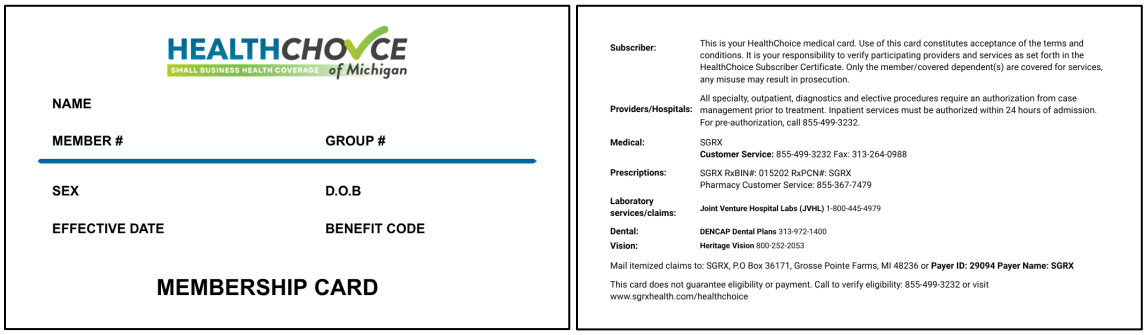
5. Member Eligibility and Enrollment

Eligibility for this plan may change monthly, Providers must verify member eligibility before rendering services using:

- The Provider Portal available at: https://sgrxhealth.com/healthchoice
- Phone: 855.499.3232, Select option: Eligibility Verification

Member Identification Card Includes:

- Member name and ID
- Effective Date
- Customer service contact information
- Payer ID



6. Benefits and Covered Services

List core covered services including preventive, primary, specialty, behavioral health, and emergency care.

HealthChoice of Michigan provides comprehensive health coverage including:

- Preventive and primary care
- Specialty and diagnostic services
- Behavioral health and substance use disorder services
- Emergency and urgent care
- Maternity and newborn care
- Prescription drug benefits

Benefit details are outlined in the Member Handbook and summary of benefits and available via the HealthChoice of Michigan website: https://healthchoiceofmichigan.com

7. Referral and Prior Authorization Requirements

Certain services require **prior authorization**.

A full authorization grid is maintained on the provider portal and includes, but is not limited to:

Inpatient admissions (Please note: **The inpatient benefit limit is 30 days per calendar year.**)

- Advanced imaging (CT/MRI/PET)
- Outpatient surgeries
- Home health and DME
- Specialty drugs

Note regarding Emergency Services:

- Hospital shall provide Covered Services to Members in emergency situations in accordance with all applicable federal and Michigan laws, including EMTALA. Plan shall reimburse Hospital for such emergency services at the rates and conditions set forth in the Hospital Agreement.
- Hospital shall notify Plan of any emergency admissions or services provided to Members within seventy-two (72) hours of treatment. Hospital shall cooperate with Plan in obtaining all necessary information to determine Member eligibility and coverage.

Referral forms and preauthorization requests may be submitted electronically via the SGRX portal or via fax.

- Portal: https://sgrxhealth.com/healthchoice
- Fax: 313.264.0988

8. Claims Submission and Payment Policies

8.1 Claim Submission

- Electronic: Submit via clearinghouse.
    - Payer ID: 29094
    - Payer Name: SGRX
- For providers without a clearinghouse, please submit electronic claims directly to SGRX via SGRX's clearing house partner, Smart Data Solutions (SDS).
    - Smart Data Solutions provides a form to allow providers to create a provider clearinghouse account with Smart Data Solutions. This account will allow the provider to submit claims, receive Electronic Remittance Advice (ERAs), and check claim status and eligibility for a variety of payers.
    - If you have any questions, you may contact the Smart Data Solutions support Mon-Fri 9-5 US Central Time at stream.support@sdata.us or 855-297-4436.
    - The link to create a provider clearinghouse account can be found on the Providers page of the SGRX website at: https://sgrxhealth.com/healthchoice/
- Paper: Mail paper claims to the address below.

    SGRX
    P.O. Box 36171
    Grosse Pointe Farms, MI 48236

- Time limit: Claims must be received within **365 days** of date of service for inpatient or outpatient services.
- To avoid delays associated with the processing of paper claims, providers are **encouraged to submit all claims electronically and timely**.
- All claims for covered services must be submitted using a valid National Provider Identifier and the most current CMS approved diagnostic and procedural coding available.

8.2 Clean Claim Definition

A clean claim includes all required data elements, appropriate codes, and attachments.

9. Quality Improvement Program

9.1 Mission Statement

SGRX is dedicated to maintaining and improving the health of our members by providing access to quality care based on benefit design and offering exceptional service to diverse populations.

9.2 Authority and Accountability

SGRX assumes ultimate responsibility for the Quality Improvement Program (QIP) and has established the Quality Improvement Committee to oversee this function. The Chief Clinical Officer is the individual responsible for the implementation of the QIP.

The Quality Program is based on on-going data analysis to identify the clinical needs, risk levels, and appropriate interventions to make certain that the program meets the specific needs of its members.

9.3 Purpose

The QIP provides a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service utilizing a multidimensional approach objectively and systematically. This approach enables SGRX to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and practitioners/providers. The QIP promotes the culture of quality and accountability to all employees and affiliated health personnel to provide quality of care and services to members.

The QIP incorporates continuous QI methodology that focuses on the specific needs of all stakeholders including members, health care providers, and community agencies.

10. Care Management and Utilization Management

The Utilization Management (UM) Program facilitates quality, cost-effective and medically appropriate services across a continuum of care that integrates a range of services appropriate to meet individual member needs. Services include:

- Preservice and admission review
- Concurrent review
- Transitional care
- Discharge planning
- Continuity and coordination of member care post hospital discharge
- Retrospective review
- Medical case management for specific conditions and specialized clinical programs
- Clinical policy and criteria development
- Provider appeal processing
- Utilization data analysis including monitoring for over and underutilization
- Evaluating member and provider satisfaction and,
- Staff education and quality oversight

Our UM staff is available to meet with you, your office staff, and/or your physician group to address your concerns and provide education about our programs. If you have any questions, please contact our UM Department during normal business hours.

Business Hours: Monday – Friday (excluding holidays) – 8:30 am – 5:00 pm

Visit our website for updates, frequently used forms, and professional resources:

https://sgrxhealth.com/healthchoice

Roles

UM Activities are coordinated and conducted under the direction of the Medical Director(s) (Physicians) and the Vice President of Health Care Services.

- Managers
    - Registered Nurses (RN) oversee the daily functions.
- Multidisciplinary teams are assigned to a population of members divided by employer group, provider group, or disease. The teams are comprised of:
    - Complex Case Managers (RN)
    - Clinical Case Managers (RN)
    - Utilization Management Referral Specialists
    - Utilization Management Coordinators
- The team structure promotes ownership and accountability to providers and members.
    - An RN is assigned to coordinate work, perform planning and monitor team functions.
    - Productivity reporting and expectations are monitored.
- Medical Director Physician Support includes:
    - Biweekly case review with teams.
    - Case discussion of complex or chronic illness case management cases
    - Case discussion of members with frequent emergency department (ED) use.
    - Review of cases that cannot be approved by a nurse.
    - Development of criteria/guidelines.
- Pharmacist Support
- Health Services Support includes:
    - Medical Social Worker (MSW)
    - Registered Health Information Administrator (RHIA)
    - Healthcare Data Analysts
    - UM Clinical Trainer
    - Quality Nurse Reviewers (RN)
    - Administrative and Clerical Support

Responsibilities

- Preservice and admission review
- Concurrent Review
- Facilitate care transitions
- Discharge planning
- Continuity and coordination of member care
- Case Management
- Retrospective review
- Clinical policy and criteria development
- Provider appeal processing

- Utilization data analysis including monitoring for over and under utilization
- Evaluate member and provider satisfaction with the UM program
- Staff education and oversight

Preservice and Admission Review/Authorization Requirements

Determining Services that Require Authorization

Examples of services requiring authorization:

- Scheduled outpatient services requiring authorization
- Select ambulatory surgical/diagnostic procedures
- Potentially cosmetic/experimental procedures
- Medical benefit review
- Home health care (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) (With appropriate rider coverage)
- Home intravenous (IV) infusion
- Authorization is required for all inpatient admissions
- SEMPH utilizes nationally recognized criteria to determine medical necessity.

Determining if a referral should be issued

A referral is a request by a Primary Care Physician (PCP) for a member to receive specialty services from another physician, another health care professional, or a facility. PCPs can refer a member to a provider/specialist for consultation by submitting an authorization request to SGRX.

When calling, please have patient demographic information, primary care provider, and referring specialty information available. Also please have all pertinent information regarding the service being requested and the patient's medical information, including but not limited to specialty required, number of visits, start and end date and diagnosis to facilitate appointment scheduling.

Requesting a Preservice or Admission Review

Portal

Authorization requests may be submitted via the Online Portal located at:
https://sgrxhealth.com/healthchoice

Fax

Fax your authorization request, and clinical information if required, to the UM Department at 313.264.0988. PCPs should use the SGRX referral form available via the website:
https://sgrxhealth.com/healthchoice

The UM Department can be reached at 855.499.3232.

Urgent Requests

All urgent requests must be submitted by calling the UM department at 855.499.3232. Make sure you identify the request as "urgent" to expedite the review process.

Tips to Help Expedite Authorization Decisions

- Verify the member's eligibility and benefits
- Accurately complete the authorization request forms
- Include all appropriate codes (diagnosis code(s) and procedure/item code(s)
- Submit your requests at least 14 days prior for elective services
- Refer to the "Benefits at a Glance" to determine which services require prior authorization
- Include pertinent clinical information (progress notes, lab results, photos, imaging studies)

Requesting an Elective Admission

For all elective admissions, the PCP, specialist, or facility must request authorization prior to the scheduled admission. Authorizations may be requested by phone or fax. Please include the following information:

- Member's name, beneficiary ID#, date of birth, and age
- Admission date
- Name of admitting facility and fax number
- Diagnosis and Procedure Codes
- Member's current medical condition including date of onset, duration of symptoms, and treatment rendered to date
- Proposed treatment plan
- Requesting physician's fax number
- Pertinent clinical documentation (progress notes, x-ray reports, lab results).

Process after Provider Submits Authorization

SGRX confirms the member's eligibility, benefits and provider's affiliation status.

- If the request is submitted with complete and accurate information, if appropriate, the request is reviewed against medical appropriateness criteria. The criteria sources used are one or more of the following:
    - Applicable Federal or State mandates and guidelines
    - Nationally recognized criteria
    - The Hayes Directory for New Medical Technologies
    - Internally developed medical necessity criteria
    - **Algorithms and guidelines from recognized professional societies**
    - Advice from authoritative review articles and textbooks

- If the request does not meet criteria, the UM staff will contact (via telephone, fax, and/or mail) the requestor for clarification or additional clinical information or refer the case to the SEMPH Medical Director. In the case of a pharmacy request the case may be referred to a SEMPH Healthcare Registered Pharmacist.

How will you be notified of your decision?

The decision timeframe is based upon the date on which we receive your request and the supporting clinical information. To ensure a timely decision, please provide all supporting clinical information with the initial request. We will contact you when additional clinical or clarifying information is needed. Our decisions are made in accordance with regulatory and accreditation guidelines.

Urgent Approved Requests

We will call the authorization number of the requestor and facility (if indicated) within 72 hours of the initial request.

Non-Urgent Approved Requests

We will call or fax the authorization number of the PCP, requesting physician or facility (if indicated) within 14 days of the initial request.

Urgent Denied Requests

The denial rationale for denial and the appeals process with be called to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within 14 days of the initial request.

Note: Providers may request a copy of the criteria of interest by telephone, fax, or email.

A SGRX Medical Director is available to discuss the denial decision with any treating practitioner.

Admission Review

How do we request authorization for an urgent/emergent admission?

- Providers should call UM Department
- Hospitals can call or fax the UM Department during normal business hours
    - Phone: 855.499.3232 Fax: 313.217.2040
    - For all urgent/emergent admissions, the hospital is required to provide clinical information once the determination is made to admit the member.

What type of clinical information should be provided?

Clinical information should include the member's health history, vital signs, physical assessment, consultations, current and previous treatment including those services performed in the emergency department (ED) and outpatient settings and the member's response to treatment. Please include any anticipated discharge needs.

How does SGRX perform clinical review of urgent/emergent inpatient admissions?

If the admission does not meet medical necessity criteria as an inpatient setting, the facility may admit the member to an observation setting, no authorization required. If the facility does not accept observation setting, the UM staff may request additional information and will forward the case for Medical Director Review.

When will we contact you?

- If additional clinical information is required.
- If the need for additional medical services is identified post discharge, such as home health care or home infusion.
- To notify you of our decisions:
    - When services are approved, we will call you with an authorization number and next review date
    - When services are not approved, we will call you. Written notification is also sent at the time of the decision giving you the reason for the denial. Member and provider appeal rights are included with the notification. If you would like a copy of the criteria that was used to make a denial determination, or we would like to discuss a denial decision with a Medical Director, please call SGRX
    - For urgent/emergent admissions, we will call you within 72 hours of receipt of the request.
    - If we are notified retrospectively of an admission and discharge, notification of our decision will be given within 14 days of receipt of the request.

Concurrent Review/Discharge Planning/Continuity and Coordination of Care/Post Hospital Discharge/ Managing Care Transition

Concurrent Review

Performed:

- To determine medical necessity and appropriateness of a continued inpatient stay,
- To identify appropriate ***discharge planning needs***
- To facilitate discharge to an appropriate setting in a timely manner

- To ensure ***continuity and coordination*** of the member's care. Our staff collaborates with the physician, hospital discharge planning, practitioners, and their representatives.
- Concurrent reviews are conducted once or twice a week as appropriate.

Hospital discharge planning staff is responsible for ensuring authorization is obtained by calling SGRX. The following select post discharge services require authorization and the appropriate contract riders:

- Home health care (including hospice, IV therapy, PT, OT, etc.)
- Infusion therapy
- Select durable medical equipment (DME)
- Skilled nursing facility (SNF)
- Rehabilitative services
- Hospice

Prior to or upon discharge from an inpatient facility, the hospital is responsible for providing the following information:

- Discharge date
- Discharge plan (medications, appointments, ancillary service needs, etc.)
- Place of discharge
- Member phone number
- Alternative phone number and contact

UM staff (RN) will contact the member post discharge to evaluate if prescriptions were filled and the member is taking accurately, if post discharge appointments are scheduled, and if the member is following the discharge plan. If it is determined the member requires additional services that were not ordered at discharge, the UM staff will contact the member's PCP and/or attending physician to discuss the member's needs. The UM staff will arrange home care services or equipment as necessary.

In summary the program provides:

- Three phone attempts over two (2) week period following discharge.
- Letters to members and their PCPs
- Nursing assessment work
- Assistance with follow-up appointments
- Medication compliance monitoring
- Evaluation of compliance with discharge instructions
- Evaluation of current clinical condition
- Education on disease process

Medical Case Management

Our Complex Case Managers (CM) are RNs with specialized training in the management of specific diseases. A clinical social worker is available to our team to provide psychosocial support as needed.

Their role is to improve the health and well-being of each member by educating, assisting, and facilitating access to the most appropriate health care services available. The CM has the responsibility to coordinate medical services throughout the member's continuum of care, while effectively reducing costs. The CMs assist:

- Identifying members who will benefit the most from case management services
- Developing a plan of care including problem identification, goals (including discharge from the program) and plan of care.
- Implementing interventions and service coordination within the benefit structure.
- Ensuring all services are medically necessary and provided at the appropriate level of care and in a timely manner.
- Coordinating such services as home health and hospice care, home infusion therapy, inpatient rehabilitation, and skilled nursing care. (Based on contract benefits)
- Monitoring progress towards our goals.
- Reassessment and close the member to case management when appropriate.

The CMs are available to physicians, utilization review staff, discharge planners, the patient and patent's family to answer questions, attend care conferences and assist in facilitating a discharge plan or coordinating care.

Who is eligible for case management?

All SGRX members *are* eligible for case management, and some members may be eligible for select case management programs. Members that may be referred for case management include those with:

- A known chronic disease
- Risk for developing chronic disease
- Multidisciplinary needs requiring case management intervention support
- Multiple hospital admissions with one more of the following conditions:
    - Cardiovascular Disease
    - Congestive Heart Failure
    - Chronic Obstructive Pulmonary Disease
    - End Stage Renal Disease
    - Asthma
    - Diabetes
    - Sickle Cell
    - AIDS/HIV
    - Cancer

- High Risk Obstetrics/Newborns

The following select case management programs are also available to support member's health care needs:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- End Stage Renal Disease
- Frequent ED Use

If you would like to learn more information, speak with a CM and/or refer a member for an evaluation, please call our UM Department.

How to refer a member for case management?

Call the UM Department during normal business hours.

How will you know if the member is accepted into case management?

You will receive a letter from a CM with their direct phone number.

When will you hear from us?

Our CMs perform an individualized member assessment. Following the assessment, the CM will send a letter informing you of the member's acceptance into the Case Management Program. The CM may periodically contact you regarding the member's progress.

Our CMs may contact you for other reasons:

- Coordinate a care plan
- Confirm a diagnosis
- Verify appropriate follow up
- Identify member compliance issues
- Discuss other problems and issues that may affect the member's care

Provider Appeals

The UM Appeals/Denials area coordinates the provider appeals and SGRX Medical Directors review all appeals of denied decisions. All providers have the right to appeal any denial decision made by SGRX. Our appeal process is objective, thorough, fair, and timely. A Medical Director may determine that a same specialty physician review may be needed.

The appeal process has three levels: First Level Appeal, Second Level Appeal, and Final Level Appeal. The sections below identify the submission recipient and deadlines for each

level. Appeals must be submitted in writing including the information below and supporting documentation. Incomplete appeals will be denied.

- Provider name, tax identification number, National Provider Identifier, and contact information.
- Member name, member identification number, date of birth, and dates of service.
- Claim number, authorization or reference number, billed and paid amounts, disputed amount, and denial or adjustment reason.
- A concise explanation of the requested resolution and why the original determination should be changed.
- Supporting records, such as the claim, remittance advice, authorization, medical records, operative notes, treatment plan, referral, coding guidance, contract provisions, fee schedule, and prior correspondence.

First Level Appeal
Written appeal must be submitted within **60 calendar** days of claims determination date. Appeal will be reviewed by the plan within **30 calendar** days of receipt of the appeal.

Attention: SGRX Health Appeals
Email: medicalappeals@sgrxhealth.com
Fax: 313.217.9736

Second Level Appeal
If the appeal is denied, a second level written appeal may be submitted along with new supporting documentation to the Executive Director of HealthChoice within **45 calendar** days of receipt of SGRX Health's decision. Appeal will be reviewed and a written determination made within **30 calendar** days of receipt of the appeal.

Attention: HealthChoice Executive Director
HealthChoice of Michigan
500 Griswold 15th Floor
Detroit, MI 48226

Final Level Appeal - *The decision of the HealthChoice Board of Trustees is final.*
If the Executive Director denies the appeal, a final written appeal may be submitted along with new supporting documentation to the HealthChoice Board of Trustees within **30 calendar** days of receipt of the Executive Director's decision. Appeal will be reviewed and a written determination made within **30 calendar** days of receipt of the appeal.

Attention: HealthChoice Board of Trustees
HealthChoice of Michigan
500 Griswold 15th Floor
Detroit, MI 48226

Expedited Appeal: SGRX will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request SGRX to furnish the names, titles and qualifications of any medical experts whose advice was obtained in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

Rapid Dispute Resolution

Plan supports the Michigan Department of Community Health (MDCH) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDCH Access Agreement. The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to State/Federal Regulations. Provider disputes will be reviewed to determine the appropriate resolution.

11. Member Rights and Responsibilities

Members have the right to:

- Receive respectful, non-discriminatory care
- Privacy and confidentiality of medical information
- Participate in treatment decisions
- File complaints or appeals without retaliation

Providers are required to communicate these rights and uphold all standards.

12. Provider Responsibilities

Provider agrees to accept Subscribers and provide services included in the HealthChoice of Michigan Plan to them in a manner that does not discriminate against the Subscribers as to payment source or on any basis prohibited by state or federal law or regulation. Notwithstanding this paragraph, basic inpatient services ("**Basic Services**") and all services that are supplemental to Basic Services ("**Supplemental Services**") may be provided only with prior authorization by SGRX using either the same standards as established by the Michigan Medicaid program (as these may change from time to time) or industry standards selected by SGRX which are applicable to the particular type of service and as approved by the applicable health benefit plan contract. For purposes of this Manual, Basic Services and Supplemental Services are collectively referred to as "Covered Services."

Providers must:

- Maintain accurate practice information
- Comply with access standards (e.g., appointment timeliness)
- Cooperate with audits, credentialing, and QI activities
- Provide culturally and linguistically appropriate services

13. Fraud, Waste, and Abuse Prevention

SGRX enforces a zero-tolerance policy.
Providers must report suspected FWA to the **Compliance Hotline:** 855.499.3232.
Examples include:

- Billing for non-rendered services
- Upcoding or unbundling
- Falsified records

14. Compliance, Privacy, and HIPAA

SGRX functions as a Business Associate under the Health Insurance Portability and Accountability Act (HIPAA). The TPA is contractually bound to safeguard all Protected Health Information (PHI) and to use such information solely for plan administration purposes.

Providers must comply with HIPAA Privacy and Security Rules.
All PHI must be transmitted and stored securely.
Any privacy breaches must be reported within **24 hours** of discovery.

15. Grievances, Appeals, and Dispute Resolution

15.1 Member Grievances

Managed by the Member Services department per stated timelines and in accordance with the Member Handbook and available on the website: https://sgrxhealth.com/healthchoice

15.2 Provider Payment Disputes

Managed by the Provider Network Management team along with The Claims team.

15.3 Independent Review

If not resolved internally, providers may seek review under applicable Michigan law or contract terms.

16. Termination, Sanctions, and Corrective Actions

Participation may be terminated for:

- Fraud or misconduct
- Noncompliance with plan standards
- Failure to maintain or Loss of licensure or exclusion from Medicaid, Medicare, or any other government program

Providers will receive written notice with opportunity to respond before termination (unless immediate termination is required for patient safety).

17. Pharmacy Services and Drug Formulary

- SGRX maintains a formulary updated quarterly.
- Prior authorization required for certain specialty or high-cost drugs.
- Generic substitution encouraged when available.

For drug formulary listing, please visit: https://sgrxhealth.com/healthchoice

18. Cultural Competency and Nondiscrimination

Providers are expected to deliver equitable care consistent with **Title VI**, **Section 1557 of the ACA**, and **CLAS standards**.

SGRX will monitor that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds, disabilities, gender, sexual orientation or gender identity.

SGRX is committed to "member centric" care that recognizes the beliefs, traditions, customs, and individual differences of the diverse population we serve. Identified needs and planned interventions involve member input and are vetted through the Public Policy Committee prior to full implementation.

19. Updates and Manual Revisions

This manual is reviewed and updated at least annually or as required by law.
Providers will be notified of revisions via:

- Provider bulletins as "New Star" changes 

- Updates on the Provider Portal