

## EXCLUSIONS

- Abortion
- Acupuncture/spinal manipulation and chiropractic care
- Allergy Testing
- Biofeedback
- Biopsies
- Cardiovascular studies
- Chemical dependency treatment
- Chemotherapy/radiation
- Childbirth/delivery facility services and professional services
- Cochlear implants
- Cosmetic surgery
- Dental care
- Diabetic supplies including insulin injectors and pumps
- Diagnostic colonoscopies
- Diagnostic imaging including CT/PET scans, MRIs and ultrasounds
- Diagnostic mammograms (preventive mammograms are covered)
- Diagnostic testing including non-preventive lab work
- Dialysis
- Drug testing
- Durable medical equipment including boots, canes, crutches, splints, prosthetics, orthotics, hospital beds, oxygen equipment, sleep apnea machines, walkers, wheelchairs and scooters
- Electrocardiogram
- Electrocardiography
- Emergency care including emergency room and ambulance
- Experimental drugs, procedures or studies including sleep studies
- Eye care
- Foot care
- Genetic testing including breast cancer (BRCA)
- Habilitation services
- Hearing aids
- Home health care including hospice, private duty nursing care and long-term care
- Hospitalization including facility fees and physician/surgeon fees
- Infertility treatment
- Mental health services
- Naturopathic services
- Non-preventive therapy and tests
- Nutritional supplies, vitamins or supplements
- Observation stays
- Occupational/Physical therapy including speech therapy
- Out-of-network services including care outside the United States
- Outpatient laboratory services in hospital setting
- Outpatient surgery including facility fees and physician/surgeon fees
- Pathology
- Rehabilitation services including physical therapy or substance abuse

## EXCLUSIONS (continued)

- Services for sexual dysfunction including drugs, supplies and therapy
- Sex change services including drugs, supplies and therapy
- Specialty prescription drugs
- Strength and performance services including devices and drugs
- Stress tests
- Supplementation (IV therapy)
- Surgical procedures including transplants and outpatient surgery, facility fees, physician/surgeon fees and anesthesia
- TMJ and orthognathic services
- Weight loss drugs, procedures (including gastric bypass surgery and lap banding), programs and supplies

## LIMITATIONS

- Behavioral health visits are offered through freshbenies and limited to 3 per plan year at the \$50 fee then \$85 fee per consultation thereafter.
- Birth control implants including intrauterine devices (IUD) insertion/removal - 1 per plan year unless due to medical necessity
- Breast Cancer Genetic Testing (BRCA) - counseling only; no testing
- COVID-19 testing is limited to FFCRA<sup>1</sup> and CDC<sup>2</sup> guidelines or due to medical necessity. Testing is also limited to outpatient settings excluding emergency facilities and/or hospitals.
- Prescription drug coverage is limited to the formulary list. For additional information visit <https://www.sbmabenefits.com/smithrxformulary>
- Preventive breast cancer mammography Screening - 1 per plan year
- Routine preventive/wellness visits (men, women and children) - 1 per plan year
- Timely filing on claims is 12 months from the date of service. Claims not received within the timely filing limit will be denied.

<sup>1</sup>Families First Coronavirus Response Act

<sup>2</sup>Centers for Disease Control and Prevention

## DEFINITIONS

- Counseling - providing patients with advice or education about a condition or disease and the potential treatment options available
- Medical Necessity - determined to be of need as evidenced by documented diagnosis from an individual's attending healthcare provider
- Screening - a method of identifying a medical condition or disease without the existence of any signs or symptoms
- Testing - a process or procedure performed to detect, diagnose or monitor a condition or disease based on a patient's illness, injury or symptoms

THIS LIST IS NOT INTENDED TO BE A COMPLETE LIST OF EXCLUSIONS. ADDITIONAL EXCLUSIONS/LIMITATIONS MAY APPLY. ONLY THE SERVICES LISTED UNDER THE SUMMARY OF BENEFITS ARE COVERED BY THE PLAN. AN OMISSION OF A NON-COVERED SERVICE FROM THE EXCLUSIONS LIST DOES NOT IMPLY THE SERVICE IS COVERED BY THE PLAN. MEMBERS AND PROVIDERS ARE ADVISED TO CONFIRM IF SERVICES ARE COVERED BY THE PLAN PRIOR TO THE SERVICES BEING RENDERED.

Any claims received for excluded services, or outside the coverage limitations listed above, will be denied and members will be responsible for the full out-of-pocket expense of the claim.