

NORTHERN NEW ENGLAND BENEFIT TRUST

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT



Please Note That These Benefits Are Administered By

CIGNA BEHAVIORAL HEALTH

Please contact CIGNA Member Services
1-800-244-6224

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

If you or a covered dependent requires Mental Health or Substance Abuse treatment, you must call CIGNA Member Services (1-800-244-6224) prior to starting the treatment to ensure that your provider is part of the CIGNA Open Access network. Through www.cigna.com you may search for Behavioral Health Providers in the network.

Managed Care Requirements

Managed care helps Northern New England Benefit Trust make sure that the care you and your covered dependents receive is the best way to treat your condition. The process also helps to ensure that you receive the best possible treatment and services in the most cost-effective manner. Please remember that managed care requirements apply regardless of whether you use an In-Network or Out-of-Network provider.

You may be asked to present your CIGNA membership card when you receive care. The card does not guarantee coverage. You must comply with all terms and conditions of the plan. Willful misuse of the card and/or plan is considered fraud.

Inpatient Care

Pre-admission Certification

When using an In-Network Provider, the provider will coordinate all pre-admission certification.

If using an Out-of-Network Provider: You must contact CIGNA Member Services (1-800-244-6224) at least seven days before the admission is scheduled. A CIGNA Managed Care Coordinator will contact both your provider and the facility to ensure that the stay is necessary and appropriate. If you fail to get pre-admission certification, you will be subject to a \$250 penalty in addition to any deductible and coinsurance and this penalty will not be applied toward your deductible or annual out-of-pocket maximum. Also, if CIGNA finds that you were hospitalized for days that were not medically necessary for your condition, room and board charges for those days will be denied under the Plan; no benefits will be paid; and the expenses you pay will not be applied toward the out-of-pocket maximum.

Retrospective Review

When you or a covered dependent receives hospital services without pre-certification or any notice to CIGNA, a thorough review of your stay will take place. During this review, CIGNA may discover treatment that was not medically necessary or appropriate. Benefits may be reduced or even denied as a result of the review findings. Reviews are conducted on every case of this nature, regardless of whether the Trust was responsible as the primary or secondary payer.

Continued Stay Review

When you or a covered dependent is in the hospital, CIGNA will monitor your treatment plan to determine if the services being provided are medically necessary and appropriate. A Managed Care Coordinator will either travel directly to the hospital or discuss the case with the staff by phone. The coordinator reviews the medical records during the hospital stay and remains in close contact with the attending physician and any other medical professionals responsible for the care. The coordinator may recommend a different length of stay or level of treatment depending on the results of conferences with the doctors and staff assigned to the case.

Outpatient Care

Open Access Program

You may receive care through a network of CIGNA providers. By using these In-Network providers, benefits will be paid at a higher rate. You still have complete choice over mental health/substance abuse provider(s), but you will pay more for care when you use an Out-of-Network provider.

In-Network Office Visits

When you or a covered dependent visits an In-Network provider, your copayment will be the same amount as a visit to your Primary Care Physician (PCP). Such copayments are not applied to your out-of-pocket maximum. *Please see your Benefit Summary for your PCP copayment.*

Out-Of Network Services

When you or a covered dependent uses an Out-of-Network provider for services, benefits are paid subject to both the Plan Deductible and Plan Coinsurance. *Please see your Benefit Summary for your deductible and coinsurance amounts.*

Out-of-Area Emergencies

The Trust provides benefits for out-of-area emergencies on an In-Network basis. When you receive emergency care outside of your immediate area, CIGNA will review the emergency care given and determine the benefits you receive based on that review. Each such emergency case is reviewed separately.

Filing Claims

In-Network Provider

You will not have to file a claim if you use the services of an in-network provider. Claims will be submitted directly to CIGNA HealthCare.

Out-of Network Provider

If you choose to use the services of an Out-of-Network provider, you should file a claim within 20 days after the beginning of the illness or injury. ***Claims received more than one year after the loss or expense is incurred will not be covered under the Plan.***

You should submit the charges even if you are not certain that the expense is covered. Benefits will be determined according to Plan provisions. Send the itemized bill directly to:

**CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422-7223**

No claim forms are required. Each provider's bill sent to CIGNA HealthCare must be itemized. This means that the bill must show all of the following:

1. provider's name and address;
2. member's name and social security number;
3. patient's name;
4. the diagnosis or the name of the condition being treated; and
5. the date, charge and type of expense for each service billed.

NOTE: Incomplete information will cause a delay in processing your claim. Receipts, balance forward statements or canceled checks cannot be used in place of itemized bills.

Once the complete claim information is received, CIGNA HealthCare reviews the claim and pays or denies the claim based on your plan of benefits. ***Claim payments are made directly to the provider of service unless you submit proof of payment with your claim.*** When claims are processed, you will be sent a worksheet showing how your benefits were calculated. This is called an "Explanation of Benefits" (EOB).

Behavioral Health Care Providers

Mental Health Care Facility

An institution or part thereof which:

- specializes in the diagnosis and treatment of mental illness or functional nervous disorder;
- is licensed to give medical treatment;
- is operated under the supervision of a physician;
- offers nursing service by registered graduate nurses (R.N.) or licensed practical nurses (L.P.N.);
- provides on the premises all the necessary facilities for medical treatment;
- is licensed by the agency responsible for regulating Mental Health Care Facilities; and
- may not be a place of rest, a place for the aged, or a place for custodial care.

Substance Abuse Treatment Facility

A private or public program, institution or portion thereof which:

- provides services for detoxification and/or rehabilitation of substance abusers
- furnishes mental health services with the approval of the appropriate governmental authority (such as a comprehensive health service organization, community mental health center, mental health clinic, or day treatment center).

Physicians

Each of the following must be licensed or certified by the state in which services are rendered and act within the scope of such license.

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Psychologist (Ed.D., Psy.D. or Ph.D.)
- Pastoral Counselor
- Social Worker (L.C.S.W. or M.S.W.)
- Licensed Mental Health Counselor (L.M.H.C)
- Licensed Alcohol & Drug Counselor (L.A.D.C)
- Licensed Marriage & Family Therapist (L.M.F.T)
- Psychiatric-Mental Health Clinical Nurse
- Advanced Registered Nurse Practitioner