Member Benefits and Services

Effective July 1, 2020

As a member of Horizon NJ Health, you get the benefits and services you are entitled to with the NJ FamilyCare Program. The medical care and services you get through Horizon NJ Health are free or low cost. Your benefit package is determined by the NJ FamilyCare Program based on your income level and the number of people in your family.

We want you to understand the services you can get with your benefits. If you are not sure whether a service is covered, just call Member Services and ask. Call toll free at **1-800-682-9090**. People with hearing or speech difficulties can use our TTY service at **711**.

What Horizon NJ Health Covers	BENEFIT PLAN TYPE			
BENEFIT	NJ FAMILYCARE **A/ABP**	NJ FAMILYCARE **B**	NJ FAMILYCARE **C**	NJ FAMILYCARE **D**
Abortions & Related Services	Covered by FFS.* Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests			
Acupuncture	Covered.			
Autism Services	Covered. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services. Applied Behavior Analysis (ABA) treatment; and DIR services (Developmental, Individual-differences and Relationship-based model).			
Blood & Blood Plasma	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.			
Bone Mass Measurement	Covered Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			
Cardiovascular Screenings	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.			
Chiropractic Services	Covered. Covers manipulation of the spine.			
Colorectal Screening	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for members 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer. • Barium Enema – Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months. • Colonoscopy – Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy. • Fecal Occult Blood Test – Covered. Covered once every 12 months. • Flexible Sigmoidoscopy – Covered. Covered once every 48 months.			

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BENEFIT	NJ FAMILYCARE **A/ABP**	NJ FAMILYCARE **B**	NJ FAMILYCARE **C**	NJ FAMILYCARE **D**
Dental Benefits	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services. Examples of covered services include (but are not limited to): routine examinations, fillings, crowns, root planing and scaling, X-rays and other diagnostic imaging, extractions, cleanings/ prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics. Orthodontics (with age restrictions and documentation of medical necessity) is also covered. *Orthodontics are covered up to age 21 for NJ FamilyCare A and ABP members.*	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services. Examples of covered services include (but are not limited to): routine examinations, fillings, crowns, root planing and scaling, X-rays and other diagnostic imaging, extractions, cleanings/ prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics. Orthodontics (with age restrictions and documentation of medical necessity) is also covered. *Orthodontics are covered up to age 19 for NJ FamilyCare B members.*	Covered. Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services. Examples of covered services include (but are not limited to): routine examinations, fillings, crowns, root planing and scaling, X-rays and other diagnostic imaging, extractions, cleanings/ prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics. Orthodontics (with age restrictions and documentation of medical necessity) is also covered. *Orthodontics are covered up to age 19 for NJ FamilyCare C and D members.* $5 copay per dental visit (except for diagnostic and preventive services).	
Diabetes Screenings	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.			

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Diabetes Supplies	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist or pedorthist.			
Diabetes Testing and Monitoring	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.			
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered. Including (but not limited to) CT scans, MRIs, EKGs and X-rays.			
Durable Medical Equipment (DME)	Covered.			
Emergency Care	Covered. Covers emergency department and physician services.		Covered. Covers emergency department and physician services. $10 copay	Covered. Covers emergency department and physician services. $35 copay
EPSDT (Early and Periodic Screening, Diagnosis and Treatment)	Covered. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, vision and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations (including the full childhood immunization schedule), lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. *Coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.*		

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Family Planning Services and Supplies	Covered. Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Services furnished by out-of-network providers are covered by Medicaid Fee-for-Service. *Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).*			
Federally Qualified Health Centers (FQHC)	Covered. Includes outpatient and primary care services from community-based organizations.			
Hearing Services/ Audiology	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.			
Home Health Agency Services	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.			
Hospice Care Services	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. • Covered in the community as well as in institutional settings. • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care. NOTE: Any care unrelated to the member's terminal condition is covered in the same manner as it would be under other circumstances.			
Immunizations	Covered. Influenza, Hepatitis B, pneumococcal vaccinations and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as part of EPSDT.			

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Inpatient Hospital Care	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital. • Acute Care – Covered. Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance). • Psychiatric – *For coverage details, please refer to the Behavioral Health chart.*			
Mammograms	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.			
Maternal and Child Health Services	Covered. Covers medical services, including related newborn care and hearing screenings. Also covers childbirth education, as well as lactation (breast feeding) supplies and support services.			
Medical Day Care (Adult Day Health Services)	Covered. Covered with a $5 copayment for each visit. No copayment for well-child visits, lead screening/ treatment, age-appropriate immunizations, prenatal care or Pap tests.	Not covered		
Nurse Midwife Services	Covered		Covered. $5 copay for each visit (except for prenatal care visits)	

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Nursing Facility Services	Covered. Members may have patient pay liability. • Long Term (Custodial Care) – Covered. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability. • Nursing Facility (Hospice) – Covered. Hospice care can be covered in a Nursing Facility setting. **See Hospice Care Services.* • Nursing Facility (Skilled) – Covered. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting. • Nursing Facility (Special Care) – Covered. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	Not covered		

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Organ Transplants	Covered. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.			
Outpatient Surgery	Covered.			
Outpatient Hospital/ Clinic Visits	Covered.		Covered. $5 copay per visit (no copay if the visit is for preventive services).	
Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered. Covers physical therapy, occupational therapy, speech pathology and cognitive rehabilitation therapy.	Covered. Covers physical, occupational, and speech/language therapy. *Limited to 60 days per therapy per calendar year.*		
Pap Smears and Pelvic Exams	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.			
Personal Care Assistance	Covered. Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	Not covered		

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Podiatry	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. *Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.*		Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. $5 copay per visit *Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.*	
Prescription Drugs	Covered. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, iron, zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.		Covered. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, iron, zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered. $1 copay for generic drugs and $5 copay for brand name drugs.	
Physician Services – Primary and Specialty Care	Covered. Covers medically necessary services and certain preventive services in outpatient settings.		Covered. Covers medically necessary services and certain preventive services in outpatient settings. $5 copay for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).	

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Private Duty Nursing	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age and to members with MLTSS (of any age).			
Prostate Cancer Screening	Covered. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.			
Prosthetics and Orthotics	Covered. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids and dentures.			
Renal Dialysis	Covered.			
Routine Annual Physical Exams	Covered.			
Smoking/Vaping Cessation	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: • NJ Quitline: Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS** (**1-866-657 8677**) (TTY **711**), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at **njquitline.org**. • NJ QuitNet: Free peer support and trained counselors, available 24 hours a day, seven days a week at **quitnet.com**. • NJ Quitcenters: Receive professional face-to-face counseling in individual or group sessions. Locate a center by calling **1-866-657-8677** (TTY **711**) or visit **quitnet.com**.			
Transportation (Emergency) (Ambulance, Mobile Intensive Care Unit)	Covered. Coverage for eamergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.			

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<table>
<tr><th>What Horizon NJ Health Covers</th><th colspan="4">BENEFIT PLAN TYPE</th></tr>
<tr><th>BENEFIT</th><th>NJ FAMILYCARE A/ABP</th><th>NJ FAMILYCARE B</th><th>NJ FAMILYCARE C</th><th>NJ FAMILYCARE D</th></tr>
<tr><td>Transportation (Non-Emergent) (Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)</td><td>Covered by FFS.
Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered.
May require medical orders or other coordination by the health plan, PCP, or providers.</td><td colspan="3">Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). May require medical orders or other coordination by the health plan, PCP, or providers.
Exceptions: Livery transportation services are not covered.</td></tr>
<tr><td>Urgent Medical Care</td><td colspan="2">Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).</td><td colspan="2">Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).
NOTE: There may be a $5 copay for urgent medical care provided by a physician, optometrist, dentist or nurse practitioner.</td></tr>
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Vision Care Services	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for members with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.		Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for members with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma Certain additional diagnostic tests are covered for members with age-related macular degeneration. $5 copay per visit for Optometrist services.	

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Behavioral health benefits

Horizon NJ Health covers a number of Behavioral Health benefits for you. Behavioral Health includes both Mental Health services and Substance Use Disorder Treatment services. Some services are covered for you by Horizon NJ Health, while some are paid for directly by Medicaid Fee-for-Service (FFS). You will find details in the chart below.

BENEFIT	MEMBERS IN DDD, MLTSS, OR FIDE SNP	NJ FAMILYCARE **PLAN A/ABP**	NJ FAMILYCARE **PLAN B**	NJ FAMILYCARE **PLAN C**	NJ FAMILYCARE **PLAN D**
MENTAL HEALTH					
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered for DDD, FIDE-SNP and MLTSS members. All other members are covered by Fee-for-Service. • Prior authorization required; 25 hours per week limit	Covered by FFS.	Not covered		
Inpatient Psychiatric	Covered	Covered. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF) or critical access hospital.			
Independent Practitioner Network or IPN (Psychiatrist, Psychologist or APN)	Covered	Covered by FFS.			

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MENTAL HEALTH (CONTINUED)					
Outpatient Mental Health	Covered.	Covered by FFS. **Coverage includes services received in a General Hospital Outpatient setting, Mental Health Outpatient Clinic/Hospital services, and outpatient services received in a Private Psychiatric Hospital.** Services in these settings are covered for members of all ages.			
Partial Care (Mental Health)	Covered.	Covered by FFS. *Limited to 25 hour per week (5 hours per day, 5 days per week).* *Prior authorization required.*			
Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization	Covered.	Covered by FFS. *Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.*			
Psychiatric Emergency Services (PES)/ Affiliated Emergency Services (AES)	Covered by FFS.				
SUBSTANCE USE DISORDER TREATMENT	**The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).**				
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification **ASAM 2 – WM**	Covered.	Covered by FFS.			

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SUBSTANCE USE DISORDER TREATMENT (CONTINUED)					
Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital-based) **ASAM 4 - WM**	Covered.				
Long Term Residential (LTR) **ASAM 3.1**	Covered.	Covered by FFS.			
Office-Based Addiction Treatment (OBAT)	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.				
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management **ASAM 3.7 – WM**	Covered.	Covered by FFS.			
Opioid Treatment Services	Covered.	Covered by FFS. Includes coverage for Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment. Coverage for Non-Methadone Medication Assisted Treatment includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.			
Peer Recovery Support Services	Covered.	Covered by FFS. Certified Peer Recovery Specialists (CPRSs) provide non-clinical assistance and support throughout all stages of the Substance Use Disorder recovery rehabilitation process.			

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SUBSTANCE USE DISORDER TREATMENT (CONTINUED)					
Substance Use Disorder Intensive Outpatient (IOP) **ASAM 2.1**	Covered.	Covered by FFS.			
Substance Use Disorder Outpatient (OP) **ASAM 1**	Covered.	Covered by FFS.			
Substance Use Disorder Partial Care (PC) **ASAM 2.5**	Covered.	Covered by FFS.			
Substance Use Disorder Short Term Residential (STR) **ASAM 3.7**	Covered.	Covered by FFS.			

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Services not covered by NJ FamilyCare Fee-for-Service or Horizon NJ Health

Services not covered by Horizon NJ Health or the NJ FamilyCare Fee-for-Service program include:

- All services not medically necessary, provided, approved or arranged by a Horizon NJ Health participating doctor (within his or her scope of practice) except emergency services.
- Any service or items for which a provider does not normally charge.
- Cosmetic services or surgery except when medically necessary and approved.
- Experimental procedures or experimental organ transplants.
- Services provided by or in an institution run by the federal government, such as the Veterans Administration hospitals.
- Respite care (except MLTSS members).
- Rest cures, personal comfort, convenience items and services and supplies not directly related to the care of the patient. Examples include guest meals and telephone charges. Costs incurred by an accompanying parent(s) for an out-of-state medical intervention are covered under EPSDT.
- Services in which health care records do not reflect the requirements of the procedure described or procedure code used by the provider.
- Services provided by an immediate relative or household member.
- Services involving the use of equipment in facilities in which its purchase, rental or construction has not been approved by the State of New Jersey.
- Services resulting from any work-related condition or accidental injury when benefits are available from any workers' compensation law, temporary disability benefits law, occupational disease law or similar law.
- Services provided or started while on active duty in the military.
- Services or items reimbursed based on submission of a cost study in which there is no evidence to support the costs allegedly incurred or beneficiary income to make up for those costs. If financial records are not available, a provider may verify costs or available income using other evidence that the NJ FamilyCare program accepts.
- Services provided outside the United States and its territories.
- Infertility diagnoses and treatment services (including sterilization reversals and related medical and clinic office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures).
- Services provided without charge. Programs offered free of charge through public or voluntary agencies should be used to the fullest extent possible.
- Any service covered under any other insurance policy or other private or governmental health benefit system or third-party liability.

Notice of Nondiscrimination

Horizon NJ Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon NJ Health provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services

Please call Member Services at **1-800-682-9090** (TTY **711**) or the phone number on the back of your member ID card, if you need the free aids and services noted above and for all other Member Services issues, including:

- Claim, benefits or enrollment inquiries
- Lost/stolen ID cards
- Address changes
- Any other inquiry related to your benefits or health plan

Filing a Section 1557 Grievance

If you believe that Horizon NJ Health has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age, or disability, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon NJ Health's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon NJ Health – Civil Rights Coordinator
PO Box 10194
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or **1-800-537-7697** (TTY)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Para ayuda en español, llame a **1-800-682-9090** (TTY **711**).

Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-682-9090 (TTY 711). This document is also available in other languages, as well as other formats, such as large print and Braille.

ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüistica. Llame al **1-800-682-9090** (**TTY 711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-682-9090** (TTY **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-682-9090 (TTY **711**) 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para **1-800-682-9090** (TTY **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-682-9090** (TTY **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-682-9090** (TTY **711**).

Multi-language Interpreter Services

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-682-9090** (TTY **711**).

ملحوظة: إذا كنت تتحدث اللغة العربية، فتتوافر لديك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-800-682-9090 (رقم هاتف الصم والبكم: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-682-9090** (TTY **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-682-9090** (телетайп **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-682-9090** (TTY **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-682-9090** (TTY **711**) पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-682-9090** (TTY **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-682-9090** (ATS **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-682-9090** (TTY **711**).

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