You deserve quality health care coverage. Now that you have joined Horizon NJ Health, you can count on it. The Managed Long Term Services & Supports (MLTSS) program is designed for people who have NJ FamilyCare and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible. You also get the special comfort of knowing that you are with the plan backed by Horizon Blue Cross Blue Shield of New Jersey. And the best part is that all of this is covered at little or no cost to you.

This MLTSS Member Handbook tells you about the benefits Horizon NJ Health covers for those enrolled in the MLTSS program. It also tells you about your rights and responsibilities and how to request a service and file a grievance.

So welcome and thank you for joining Horizon NJ Health.

Remember, if you have questions any time – day or night – call our Member Services Department toll free at 1-844-444-4410 (TTY 711).

You may also write to Horizon NJ Health at:

Horizon NJ Health
MLTSS Member Services
1700 American Blvd.
Pennington, NJ 08534

We are here to help you.

Important Phone Numbers

<table>
<thead>
<tr>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
</tr>
<tr>
<td>TTY Services</td>
</tr>
<tr>
<td>24/7 Nurse Line</td>
</tr>
<tr>
<td>Printed Member Materials</td>
</tr>
</tbody>
</table>

A knowledgeable representative is available to help you 24 hours a day, seven days a week: 1-844-444-4410

For people with hearing or speech difficulties: 711

1-800-711-5952

If you need additional materials, like a member handbook or provider directory, please call 1-844-444-4410 (TTY 711). Horizon NJ Health is required to supply information about these materials, including options counseling. There is no charge for printed materials and the request will be processed within five (5) business days.

Words to Know

We’ve highlighted some key words throughout this handbook. Look for these boxes for definitions that will help you get the most from your Horizon NJ Health membership.
Always have it available

Before your membership begins, a Horizon NJ Health MLTSS ID card is mailed to you. Always carry your Horizon NJ Health ID card with you. It is one of the most important cards you have.

Show your card every time you get health care – when you see your personal Horizon NJ Health doctor or dentist, when you visit a specialist, when you fill a prescription, when you have lab work done, and if you go to a hospital Emergency Room (ER). You can use your card as long as you are a member.

Please keep your Horizon NJ Health MLTSS member ID card safe and never let anyone else use or borrow it. It is illegal to lend your member ID card or number to anyone. You could lose your NJ FamilyCare benefits and may even go to jail.

What is on the ID card

- Name of the member
- Effective date – the date your Horizon NJ Health benefits begin
- Your doctor’s name and phone number
- A phone number to help you access information on your dental benefits
- Our toll-free Member Services phone number (back of the card)
- Information on what to do in an emergency (back of the card)

If it is lost or stolen

If your member ID card is lost or stolen, call Member Services right away. We will send you a new one.

Other ID cards

You should carry your Health Benefits Identification (HBID) card sent to you by the State of New Jersey, along with your Horizon NJ Health ID card and any other cards for other health insurance you may have, including Medicare. Show all your cards any time you visit a doctor, dentist, hospital, pharmacy, lab or other provider. This will help make sure that all your providers know how to bill for services or prescriptions.

You will need to show your doctor the HBID card to get NJ FamilyCare Fee-for-Service benefits not covered by Horizon NJ Health (see the Your Benefits section on page 13).

Your Horizon NJ Health MLTSS ID Card

Words to Know

Benefit: Service given to a person that is paid for by the health plan
As a Horizon NJ Health MLTSS member you have easy and secure access to our online member support services. The following features will be available to you once you sign up:

- **Request an ID card** – if you need a new ID card, you can easily request one to be sent to you.
- **View your covered benefits** – learn about your benefit level, and what is covered under your plan. MLTSS members do not have copayments for MLTSS services, but they do have a cost share, or Patient Payment Liability for Assisted Living and Nursing Facilities.
- **Complete a Health Needs Survey** – this assessment about your health will help us learn about your risks, and see how you can make changes to your lifestyle to improve your health.
- **Change your Primary Care Provider (PCP)** – if you need to change your doctor, you can easily do this online.

Additional features include:

- **Find a dentist or dental specialist**
- **Wellness Topics** – get personalized health news articles from WebMD, based on the information you provide in your health assessment.
- **Enroll in a Disease Management program** – if you have a chronic condition, like asthma or diabetes, you can enroll in a specific disease management program to help manage your health issue(s).
- **Enroll in Mom’s GEMS maternity program** – if you are pregnant, you can enroll in the Mom’s GEMS program to get information for a healthy pregnancy and healthy baby.

To register for online member support services, visit our website at horizonNJhealth.com and click Member Sign In. We encourage you to sign up as soon as possible. You will find this self-service tool to be a useful resource for managing your health plan!

### Provider Directory

Horizon NJ Health has a large network of doctors and other health care professionals that provide quality health care services to our members. This list is called the Provider Directory. All types of providers are listed, including doctors, hospitals, laboratory services, pharmacies, general dentists, dental specialists, and more. There are three different ways to view the Provider Directory:

1. **Online at horizonNJhealth.com** – updated daily, this web-based directory, Doctor & Hospital Finder, lets you search for a provider by location, specialty, name and other fields. All types of providers are listed, including doctors, hospitals, laboratory services, pharmacies, general dentists and dental specialists.
2. **County-specific provider directory** – updated monthly, this directory is mailed to new members. It lists PCPs, general dentists and dental specialists, hospitals, pharmacists and other commonly needed providers in and around a member’s county.
3. **Provider Directory** – updated twice a year, this book lists all specialists, hospitals, pharmacists and other providers.

### Selecting your Horizon NJ Health doctor

You can choose a personal Horizon NJ Health doctor, known as a Primary Care Provider (PCP). Use the Horizon NJ Health Provider Directory to find a doctor near you. An authorized person acting for you may help you choose a doctor. If you did not select a PCP on your enrollment form, we selected one for you based on where you live and your age. Call Member Services if you would like to change your PCP. Member Services can also help you find a doctor in your area.

### The role of your PCP

Call your doctor’s office first – 24 hours a day, seven days a week – whenever you need medical care. Your doctor will know how to help. Most non-emergency health care services must be planned through your Horizon NJ Health PCP. Your health services are covered 24 hours a day, seven days a week. Horizon NJ Health covers services by PCPs, specialists, certified nurse midwives, certified nurse practitioners, clinical nurse specialists, physician assistants and independent clinics in Horizon NJ Health’s network. Your PCP may sometimes ask other health care providers to help give you timely care. You may ask to have a Horizon NJ Health participating specialist as your PCP. You may also request a referral to certain care facilities for highly specialized care or to continue care with a non-participating doctor. These requests will be made through your Care Manager.
Questions and answers about your doctor and dentist

Q. If I have Medicare and NJ FamilyCare, do I need to see my Horizon NJ Health PCP?
A. For most health services, you can see your Medicare doctors as long as they accept patients who have Medicare.

There are health services that Medicare does not cover, but NJ FamilyCare does. These include but are not limited to:
- Dental services (including treatment by dental specialists)
- Vision services
- Hearing services
- Incontinence supplies
- Personal care assistant services (agency or Personal Preference Program)
- Medical day care

MLTSS members may also be eligible for certain MLTSS services. These can include but are not limited to:
- Home delivered meals
- Personal Emergency Response System
- Home based supportive care
- Chore services

Q. What if I want to change my doctor or dentist?
A. You can change your PCP at any time. Member Services can help you choose a new doctor and will send you a new Horizon NJ Health member ID card with the new doctor’s name and phone number. You can also request to change your PCP through Horizon NJ Health Member Online Services.

If you want to change your dentist, you may select one from our list of participating providers at horizonNJhealth.com. Simply click: Need a Doctor and select Dentist, or call Member Services for assistance at 1-844-444-4410 (TTY 711).

Sometimes, Horizon NJ Health reserves the right to deny a request to change to a new doctor. Situations where Horizon NJ Health may deny a request include:
- If a PCP asks that a member not be included on his or her list of patients
- If a PCP has too many patients to take any more

Creating a positive, healthy relationship with your doctor is important. If your PCP believes that he or she cannot do this with a member, they may ask that the member be changed to another PCP. Other times in which a PCP may ask that a member be changed to another doctor include:
- If they cannot solve conflicts with the member
- If a member does not follow health care instructions, which stops the doctor from safely or ethically proceeding with the member’s health care services
- If a member has taken legal action against the PCP

Q. How do I know if I should go to a doctor or dentist for care?
A. To help choose between going to your medical doctor or a dentist, use the following as a guide:
- Medical treatment most often involves services not directly involving the teeth, such as treatment for broken jaws or removal of cysts and benign or malignant tumors in the mouth.

Q. What if I need to see a specialist?
A. Your PCP will make the decision to send you to a participating specialist. You must have a referral to see a participating specialist. An eye doctor (for a medical problem such as cataracts or an eye infection) or a heart specialist are types of doctors you need a referral to see. Your PCP will send an electronic referral to the specialist.

You do not need a referral to participating providers for:
- Routine gynecological/obstetrical (Ob/Gyn) care
- Family planning services
- Mammograms
- Routine eye examinations by an optometrist or eye doctor
- Dental care, including care from dental specialists
- Mental health or substance use disorder services

Q. What if my condition requires care from a doctor who does not participate with Horizon NJ Health?
A. Horizon NJ Health has thousands of doctors and specialists throughout New Jersey in our network. If we do not have a doctor to care for your condition, we will work with your PCP or dentist to make sure you get the care you need. You may also get special approval from Horizon NJ Health for an out-of-network doctor if your medical condition requires it. Your doctor will need to contact Horizon NJ Health and talk to our Authorization Unit. If you use an out-of-network doctor without approval from Horizon NJ Health, you will have to pay for those services on your own.

Q. What if I want a second opinion?
A. You can ask for another doctor’s opinion for any medical, dental, mental health, substance use disorder or surgical diagnosis. Talk to your PCP or dentist about a second opinion. He or she will make all of the arrangements, or you may call Member Services for help finding

Words to Know

Specialist: A doctor or dentist who has been specially trained in a certain field of medicine, like a cardiologist, Ob/Gyn or orthodontist.

Personal Care Assistant: Staff that assist members with hands-on activities of daily living (e.g., bathing, dressing)

Referral: Approval from a PCP to visit a specialist. The doctor will send an electronic referral to the specialist you need to see.

Services at a Federally Qualified Health Center (FQHC), government-funded community health centers that deliver high quality health care to all people, regardless of their ability to pay

Emergency Room (ER) visits

Medicare-covered services for members enrolled in Medicare

If you have a condition that needs ongoing care from a participating specialist (such as kidney disease or HIV) or you have a life-threatening or disabling condition or disease, you can ask your PCP for a “standing referral.” A standing referral lets you go to your specialist as often as the specialist needs to see you to treat your medical condition. The specialist may be able to act as your PCP and specialty care provider. Your Care Manager can help you with this request.
A. If you have any questions about how to get
and screenings you need and how often you
smoke) and other factors impact what services
you eat, how active you are and whether you
problems before they start. They can also
return your call within one business day.
A. What if I have questions about MLTSS
eligibility requirements?
B. MLTSS Member Services team
TTY 711). Your Care Manager is available
Monday through Friday, from 8 a.m. to 5 p.m.
At other times, an MLTSS Care Manager is
on-call and available to assist you 24 hours
a day, seven days a week. You may also call
to leave a message for your Care Manager, if
preferred. When leaving a message, please be
sure to give enough detail for us to
understand why you are calling. We will
return your call within one business day.
Q. What if I have questions about
authorizations for MLTSS covered services?
A. If you have any questions about how to get
covered MLTSS services authorized or if you
are not sure whether a service is covered,
MLTSS Member Services is available to assist
you 24 hours a day, seven days a week at
1-844-444-4410 (TTY 711). A member’s
Service Plan of Care (SPOC) is developed
collaboratively between members and their
Care Manager and needed services are
authorized based on the member’s SPOC.

Make an appointment right away

Soon after becoming a member, you should see
your PCP. A baseline physical will let your doctor
measure your health, review your health history
and help prevent future health problems. It is
also important to complete all treatment which
your dentist recommends. We will encourage
your PCP’s office to contact you to schedule the
appointment if you do not schedule one. Your
PCP’s office should schedule appointments for
routine visits within 28 days of your request.
Now would also be a good time to schedule a
dental exam. Children and adults should have a
dental exam and have their teeth cleaned
at least twice a year. If you need assistance
in locating a dentist for you or your child, call
Member Services at 1-844-444-4410 (TTY 711).
If you need to see your PCP before you get
your member ID card, call Member Services. A
representative will help make arrangements for
you to see your PCP.

Very important: Keep your
appointments!

When you are sick or injured and need care,
call your doctor right away for an appointment.
Sometimes, it can take a while to get an
appointment, so do not delay in calling to
schedule one.

Showing up for every doctor’s appointment is
the only way your doctor and dentist can make
sure that you are getting the quality care you
deserve. Your doctor has saved time to see you.
If you cannot keep an appointment, call and
let your doctor or dentist know right away or at
least 24 hours in advance. That way, your
doctor can use the time to help another patient. You
should make every effort to be on time to your
appointment.

Appointment availability

- Emergency services: Immediately when
you show up at an emergency care site.
- Urgent care: Within 24 hours of calling,
your doctor will see you. Urgent care
is when you need immediate medical
attention but your concern is not
life-threatening.
- Symptomatic acute care: You will be
seen within 72 hours. Having the flu is an
example of this type of care.
- Routine care: Checkups for illness, such as
diabetes or high blood pressure, are
available within 28 days.
- Specialist care: Care can be received
within four weeks, or within 24 hours for an
emergency.
- New member physicals: Appointments
should be made within 90 days of initial
enrollment for children, and 180 days of
initial enrollment for adults.
- Routine physicals: Physicals needed for
school, camp, work, etc. are scheduled
within four weeks.

- Prenatal care: If you have a positive
pregnancy test, your first appointment will
be scheduled within three weeks. Your
appointment should be scheduled within
your first trimester. If you are identified
as having a “high-risk” pregnancy, your
appointment will be within three days.
During a woman’s first and second
trimester, appointments are available within
seven days of the request. Appointments
are available within three days during the
last three months of pregnancy.
- Lab and radiology services: Appointments
are available within three weeks for routine
care and 48 hours for urgent care. Your
results will be available within ten business
days of receipt, or 24 hours for urgent care.
- Dental care: Routine care is available
within 30 days, urgent care within three days
and emergency care within 48 hours.
- Behavioral health care: Appointments
are available within ten days of referral
for routine care and 24 hours for urgent care.
If you have an emergency, you will be
seen immediately when you get to your
behavioral health provider.
- When you get to the doctor’s office on time
for your appointment, you should not have
to wait longer than 45 minutes.

Regular checkups are important

Regular medical, behavioral health
and dental exams and tests can help find
problems before they start. They can also
help find problems early. Your age, health
and family history, lifestyle choices (like what
you eat, how active you are and whether you
smoke) and other factors impact what services
and screenings you need and how often you
need them.

Remember:

- If you or your child is sick, your doctor
will see you the same day in most cases.
When should you go to the hospital Emergency Room (ER)? ONLY go when your situation is an emergency. An emergency medical condition is a severe illness or injury in which not getting immediate medical attention could put the health of the person (and with respect to a pregnant woman, the health of her unborn child) in serious danger. Emergencies involve serious injury to bodily functions or any body part.

If an emergency exists, go to the nearest ER or call 911, 24 hours a day, seven days a week. You do not need approval from Horizon NJ Health or a referral from a doctor to go to the ER. For urgent needs, call your Horizon NJ Health Care Manager. To access emergency behavioral health services call toll free 1-877-695-5612 (TTY 711).

Sometimes, it can be hard to tell if you have a real emergency. Here are some examples of emergency situations in which you should go to the ER or call 911:

- Chest pain
- Broken bones
- Difficulty breathing, moving or speaking
- Poisoning
- Heavy bleeding
- Drug overdose
- Car accident
- Thoughts of hurting yourself or others
- If you are in labor during pregnancy, follow your Ob/Gyn’s instructions on what to do

Go to the nearest hospital to treat your emergency, even if the hospital or doctor does not participate with Horizon NJ Health. All hospitals must provide emergency care.

You should contact your MLTSS Care Manager for coordination of care after an emergency room visit. Be sure to contact your PCP to continue treatment and support.

Behavioral health emergency
If you are in danger of hurting yourself or others, you should do one of the following immediately:
- Call 911 if a life is in danger
- Go to the closest emergency room for attention
- Call your PCP or mental health provider

You do not need to get approval to get emergency services. After an emergency, you should contact your provider to continue treatment and support.

Dental emergencies
A dental emergency is when injury to your mouth, or the area around your mouth, could put your life or health in danger unless you get fast treatment. Dental emergencies can include:
- A broken or dislocated jaw
- Heavy, uncontrolled bleeding
- Infection or swelling involving the face or jaw
- Pain from injuries to the mouth or jaw
- A knocked out tooth

These conditions can be dangerous to your health. Go to the ER or call 911. For the treatment of other kinds of dental emergencies, call your dentist first.

At the Emergency Room
Once at the ER, hospital staff will perform an ER screening exam. This is a covered benefit for all members to see if the condition can be reasonably considered an emergency.

An emergency medical condition occurs with certain serious symptoms (including severe pain) that would make a person believe that if he/she does not get medical help, their health (and, with respect to a pregnant woman, the health of her unborn child) is in serious danger, including serious damage to bodily functions, or serious wound to any body part.

For a pregnant woman having contractions, an emergency exists when there is not enough time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

You are covered for emergencies 24 hours a day, seven days a week. This includes follow-up care in and out of the hospital.

Within 24 hours, call your PCP or dentist to tell him or her about the visit to the ER. If you cannot call, ask a friend or family member to call. You should visit your PCP or dentist for follow-up care, not the ER. This follow-up care is sometimes called “post-stabilization care.” Your PCP or dentist will coordinate your care after the emergency.

Urgent care
If you are not sure if your illness or injury is an emergency, call your doctor or dentist first. Some examples of illness or injury that can wait until you talk to your doctor or dentist are:
- Cold, cough or sore throat
- Earaches
- Cramps
- Bruises, small cuts or minor burns
- Rashes or minor swelling
- Backaches from a pulled muscle
- Toothaches
- Swelling of the gums around a tooth
- Teething discomfort
- Broken natural teeth or lost fillings or crowns

If your situation is not an emergency, but it is medically necessary for you to get treatment quickly, call your doctor. This is known as urgent care. Your doctor or dentist can make arrangements for you to come into the office quickly for care.

Out of town?
If you have an emergency out of town, go to the nearest hospital and remember to show the hospital staff your Horizon NJ Health member ID card. You do not need to get prior approval from Horizon NJ Health for emergency services.

If you need medical attention that is not an emergency, call your PCP right away to get help to find medical care from a doctor in the area. Horizon NJ Health will coordinate your care between your PCP and the out-of-network provider. Dental emergencies are also covered and do not require prior approval. Contact your dentist or Horizon NJ Health Member Services for assistance.

Horizon NJ Health will not cover care received outside of the United States and its territories.
As a member of Horizon NJ Health, you get the benefits you are entitled to through the NJ FamilyCare program. Members with MLTSS benefits do not have copayments for covered services. MLTSS members do have a cost share, or Patient Payment Liability for Assisted Living and Nursing Facilities. Make sure you know how Horizon NJ Health works, especially when it comes to emergency care, seeing your doctor and when you need a referral. Otherwise, you might be billed if you get services that are not covered by Horizon NJ Health or authorized by your PCP. Before care is given, your doctor should tell you if a service is not covered and if you will be billed for the service. If you are not sure whether a service is covered, call Member Services toll free at 1-844-444-4410 (TTY 711).

### Your Benefits

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions and Related Services</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Covered when provided by a licensed doctor</td>
</tr>
<tr>
<td>Adult Day Health/Medical Day Care</td>
<td>Covered</td>
</tr>
<tr>
<td>Audiology</td>
<td>Covered</td>
</tr>
<tr>
<td>Blood and Blood Plasma</td>
<td>Covered</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Coverage is limited to spinal manipulation</td>
</tr>
<tr>
<td>Cognitive Rehabilitation Therapy</td>
<td>Covered</td>
</tr>
<tr>
<td>Comprehensive Dental</td>
<td>Covered. Some services require prior authorization.</td>
</tr>
<tr>
<td>Dental Orthodontics</td>
<td>Coverage includes: limited interceptive and comprehensive based on demonstrated medical necessity. Age limits apply. All services require prior authorization. Coverage is limited to members up to age 21 who require these services due to medical need, including developmental problems or jaw injury. Prior authorization required.</td>
</tr>
<tr>
<td>Diabetic Supplies and Equipment</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Assistive Technology Devices</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency Medical Care/Emergency Services</td>
<td>Covered</td>
</tr>
<tr>
<td>EPSDT (Early and Periodic Screening, Diagnosis and Treatment)</td>
<td>Covered, including medical exams, dental, vision, hearing and lead screening services. Covered for treatment services identified through the exam.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Covered. Covered by Fee-for-Service when services are not given by a Horizon NJ Health doctor.</td>
</tr>
<tr>
<td>Group Homes and DCPP Residential Treatment Facilities</td>
<td>Covered</td>
</tr>
<tr>
<td>Hearing Aid Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Home Health Agency Services</td>
<td>Covered, including nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment; physical, occupational and speech therapy services; pharmaceutical services; and durable medical equipment.</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Covered in the community as well as in institutional settings. Room and board are included only when services are delivered in an institutional (non-private residence) setting. Hospice care for children under age 21 shall cover both palliative and curative care</td>
</tr>
<tr>
<td>Hospital Services (Inpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Hospital Services (Outpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Intermediate Care Facilities/Intellectual Disability</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Covered, including routine testing related to the administration of atypical antipsychotic drugs</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Covered, including related newborn care and hearing screening</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered</td>
</tr>
</tbody>
</table>

### You have access to NJ FamilyCare benefits

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medical Care/Emergency Services</td>
<td>Covered</td>
</tr>
<tr>
<td>EPSDT (Early and Periodic Screening, Diagnosis and Treatment)</td>
<td>Covered, including medical exams, dental, vision, hearing and lead screening services. Covered for treatment services identified through the exam.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Covered. Covered by Fee-for-Service when services are not given by a Horizon NJ Health doctor.</td>
</tr>
<tr>
<td>Group Homes and DCPP Residential Treatment Facilities</td>
<td>Covered</td>
</tr>
<tr>
<td>Hearing Aid Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Home Health Agency Services</td>
<td>Covered, including nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment; physical, occupational and speech therapy services; pharmaceutical services; and durable medical equipment.</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Covered in the community as well as in institutional settings. Room and board are included only when services are delivered in an institutional (non-private residence) setting. Hospice care for children under age 21 shall cover both palliative and curative care</td>
</tr>
<tr>
<td>Hospital Services (Inpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Hospital Services (Outpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Intermediate Care Facilities/Intellectual Disability</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Covered, including routine testing related to the administration of atypical antipsychotic drugs</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Covered, including related newborn care and hearing screening</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered</td>
</tr>
</tbody>
</table>

Member Services: 1-844-444-4410  
horizonNJhealth.com
## What Horizon NJ Health Covers

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Inpatient Hospital Services (Including Acute Psychiatric Hospitals)</td>
<td>Covered</td>
</tr>
<tr>
<td>Mental Health Outpatient Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Mental Health – Home Health</td>
<td>Covered for DDD, FIDE-SNP and MLTSS members. All other members are covered by NJ FamilyCare Fee-for-Service.</td>
</tr>
<tr>
<td>Nurse Midwife</td>
<td>Covered</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>Covered</td>
</tr>
<tr>
<td>Nursing Facility Services (Custodial Care, Rehabilitation, Post-acute Care, Skilled Nursing Care and Services in Special Nursing Facilities, Such as Ventilator Facilities, Pediatric Long term Care and Treatment for AIDS)</td>
<td>Covered</td>
</tr>
<tr>
<td>Opioid Treatment (Maintenance and Administration)</td>
<td>Covered</td>
</tr>
</tbody>
</table>
| Optical Appliances | Covered for select eyeglasses and contact lenses as follows:  
- Age 18 and under and 60 and older – Replacement eyeglasses or contact lenses annually if prescription changes  
- Age 19 to 59 – Replacement eyeglasses or contact lenses every two years if prescription changes  
Replacement eyeglasses or contact lenses may be dispensed more frequently if significant vision changes occur. Contact lens exams and fittings are covered only when deemed medically necessary over glasses. |
| Optometrist Services | Covered for one routine eye exam per year. |
| Organ Transplants | Covered for transplant-related medical costs for the donor and recipient, including donor and recipient costs. |

## What Horizon NJ Health Covers

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Comprehensive Services</td>
<td>Coverage is limited to members up to age 21 who require these services due to medical need, including developmental problems or jaw injury. Prior authorization required.</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Covered for children under 19 years old when medically necessary.</td>
</tr>
<tr>
<td>Outpatient Diagnostic Testing</td>
<td>Covered</td>
</tr>
<tr>
<td>Partial Care Program</td>
<td>Covered</td>
</tr>
<tr>
<td>Partial Hospital Program</td>
<td>Covered</td>
</tr>
<tr>
<td>Personal Care Assistant (PCA) Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Personal Preference Program Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>Covered. Routine hygienic care of feet, including the treatment of corns and calluses, trimming of nails and other hygienic care in the absence of a pathological condition, is not covered.</td>
</tr>
</tbody>
</table>
| Prescription Drugs (Retail Pharmacy) | Coverage includes:  
- atypical antipsychotics,  
- Methadone, Suboxone and Subutex or any other drug within this category when used for the treatment of opioid dependence  
- drugs that may be excluded from Medicare Part D coverage  
Coverage excludes:  
- erectile dysfunction drugs; and  
- drugs not covered by a third-party Medicare Part D formulary |
| Prescription Drugs – Medicare Part B (doctor administered) | Covered |
| Primary Care, Specialty Care and Women’s Health Services | Covered |
| Private Duty Nursing | Covered |

---

Member Services: 1-844-444-4410  
horizonNJhealth.com
Your Benefits (continued)

You have access to NJ FamilyCare benefits

<table>
<thead>
<tr>
<th>What Horizon NJ Health Covers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ FamilyCare Benefit</td>
<td></td>
</tr>
<tr>
<td>Prosthetics</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology Services</td>
<td></td>
</tr>
<tr>
<td>(Diagnostic &amp; Therapeutic)</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td></td>
</tr>
<tr>
<td>(Outpatient Physical Therapy, Cognitive Rehabilitation Therapy Occupational Therapy and Speech Pathology)</td>
<td>Covered</td>
</tr>
<tr>
<td>Sex Abuse Examinations and Related Diagnostic Testing</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Specialty Foods</td>
<td></td>
</tr>
<tr>
<td>(Medical Foods)</td>
<td>Coverage is limited to nutritional supplements requiring medical supervision for members with inborn errors of metabolism and related genetic conditions. Medical foods and special diets for all other medical conditions are not covered.</td>
</tr>
<tr>
<td>Substance use</td>
<td></td>
</tr>
<tr>
<td>(Inpatient and Outpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation Services</td>
<td></td>
</tr>
<tr>
<td>- Emergency Ambulance (911)</td>
<td>Coverage is limited to medical emergencies only.</td>
</tr>
<tr>
<td>Transportation to Medically Necessary Services</td>
<td>Covered by NJ FamilyCare Fee-for-Service through LogistiCare. To schedule, call LogistiCare (State transportation contractor). NOTE: Members should call LogistiCare at 1-866-527-9933 (TTY 1-866-288-3133) to book a trip by 12:00 p.m. at least 48 hours in advance of a routine transportation need.</td>
</tr>
</tbody>
</table>

The following services may be available to you when assessed as a need and identified in your Plan of Care:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Partial Hospitalization (Mental Health)</td>
<td>Services that provide a non-residential psychiatric rehabilitation program for members with serious mental illness</td>
</tr>
<tr>
<td>Adult Family Care</td>
<td>Living in the home or apartment of a trained caregiver who provides support and services to the member</td>
</tr>
<tr>
<td>Adult Mental Health Rehabilitation (AMHR)</td>
<td>A supervised residential group home that provides mental health services</td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td>A facility licensed by the Department of Health to provide apartment-style housing</td>
</tr>
<tr>
<td>Assisted Living Program</td>
<td>Assisted living service to tenants of certain publicly subsidized senior housing buildings</td>
</tr>
<tr>
<td>Behavioral Management – Traumatic Brain Injury (TBI) (Group and Individual)</td>
<td>Program provided in or out of the home designed to treat the member and caregivers when the member has a TBI diagnosis</td>
</tr>
<tr>
<td>Caregiver/Participant Training</td>
<td>Training for caregivers</td>
</tr>
<tr>
<td>Chore Services</td>
<td>Services needed to maintain the home in a clean and safe environment; not every day housekeeping tasks</td>
</tr>
<tr>
<td>Cognitive Therapy (Group and Individual)</td>
<td>Services to help support loss in function</td>
</tr>
<tr>
<td>Community Residential Services</td>
<td>Services that help support and provide supervision for members with a TBI diagnosis</td>
</tr>
<tr>
<td>Community Transition Services</td>
<td>Services provided to help move from an institutional setting into his/her own home in the community</td>
</tr>
<tr>
<td>Home-Based Supportive Care</td>
<td>Services that assist with household needs (e.g., meal preparation, laundry)</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>Prepared meals brought to your home</td>
</tr>
</tbody>
</table>

You have access to NJ FamilyCare benefits

What Horizon NJ Health Covers

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology Services</td>
<td></td>
</tr>
<tr>
<td>(Diagnostic &amp; Therapeutic)</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation Services (Outpatient Physical Therapy, Cognitive Rehabilitation Therapy Occupational Therapy and Speech Pathology)</td>
<td>Covered</td>
</tr>
<tr>
<td>Sex Abuse Examinations and Related Diagnostic Testing</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Specialty Foods</td>
<td></td>
</tr>
<tr>
<td>(Medical Foods)</td>
<td>Coverage is limited to nutritional supplements requiring medical supervision for members with inborn errors of metabolism and related genetic conditions. Medical foods and special diets for all other medical conditions are not covered.</td>
</tr>
<tr>
<td>Substance use</td>
<td></td>
</tr>
<tr>
<td>(Inpatient and Outpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation Services</td>
<td></td>
</tr>
<tr>
<td>- Emergency Ambulance (911)</td>
<td>Coverage is limited to medical emergencies only.</td>
</tr>
<tr>
<td>Transportation to Medically Necessary Services</td>
<td>Covered by NJ FamilyCare Fee-for-Service through LogistiCare. To schedule, call LogistiCare (State transportation contractor). NOTE: Members should call LogistiCare at 1-866-527-9933 (TTY 1-866-288-3133) to book a trip by 12:00 p.m. at least 48 hours in advance of a routine transportation need.</td>
</tr>
</tbody>
</table>

The following services may be available to you when assessed as a need and identified in your Plan of Care:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Partial Hospitalization (Mental Health)</td>
<td>Services that provide a non-residential psychiatric rehabilitation program for members with serious mental illness</td>
</tr>
<tr>
<td>Adult Family Care</td>
<td>Living in the home or apartment of a trained caregiver who provides support and services to the member</td>
</tr>
<tr>
<td>Adult Mental Health Rehabilitation (AMHR)</td>
<td>A supervised residential group home that provides mental health services</td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td>A facility licensed by the Department of Health to provide apartment-style housing</td>
</tr>
<tr>
<td>Assisted Living Program</td>
<td>Assisted living service to tenants of certain publicly subsidized senior housing buildings</td>
</tr>
<tr>
<td>Behavioral Management – Traumatic Brain Injury (TBI) (Group and Individual)</td>
<td>Program provided in or out of the home designed to treat the member and caregivers when the member has a TBI diagnosis</td>
</tr>
<tr>
<td>Caregiver/Participant Training</td>
<td>Training for caregivers</td>
</tr>
<tr>
<td>Chore Services</td>
<td>Services needed to maintain the home in a clean and safe environment; not every day housekeeping tasks</td>
</tr>
<tr>
<td>Cognitive Therapy (Group and Individual)</td>
<td>Services to help support loss in function</td>
</tr>
<tr>
<td>Community Residential Services</td>
<td>Services that help support and provide supervision for members with a TBI diagnosis</td>
</tr>
<tr>
<td>Community Transition Services</td>
<td>Services provided to help move from an institutional setting into his/her own home in the community</td>
</tr>
<tr>
<td>Home-Based Supportive Care</td>
<td>Services that assist with household needs (e.g., meal preparation, laundry)</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>Prepared meals brought to your home</td>
</tr>
</tbody>
</table>

You have access to NJ FamilyCare benefits

What Horizon NJ Health Covers

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology Services</td>
<td></td>
</tr>
<tr>
<td>(Diagnostic &amp; Therapeutic)</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation Services (Outpatient Physical Therapy, Cognitive Rehabilitation Therapy Occupational Therapy and Speech Pathology)</td>
<td>Covered</td>
</tr>
<tr>
<td>Sex Abuse Examinations and Related Diagnostic Testing</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Specialty Foods</td>
<td></td>
</tr>
<tr>
<td>(Medical Foods)</td>
<td>Coverage is limited to nutritional supplements requiring medical supervision for members with inborn errors of metabolism and related genetic conditions. Medical foods and special diets for all other medical conditions are not covered.</td>
</tr>
<tr>
<td>Substance use</td>
<td></td>
</tr>
<tr>
<td>(Inpatient and Outpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation Services</td>
<td></td>
</tr>
<tr>
<td>- Emergency Ambulance (911)</td>
<td>Coverage is limited to medical emergencies only.</td>
</tr>
<tr>
<td>Transportation to Medically Necessary Services</td>
<td>Covered by NJ FamilyCare Fee-for-Service through LogistiCare. To schedule, call LogistiCare (State transportation contractor). NOTE: Members should call LogistiCare at 1-866-527-9933 (TTY 1-866-288-3133) to book a trip by 12:00 p.m. at least 48 hours in advance of a routine transportation need.</td>
</tr>
</tbody>
</table>

The following services may be available to you when assessed as a need and identified in your Plan of Care:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Partial Hospitalization (Mental Health)</td>
<td>Services that provide a non-residential psychiatric rehabilitation program for members with serious mental illness</td>
</tr>
<tr>
<td>Adult Family Care</td>
<td>Living in the home or apartment of a trained caregiver who provides support and services to the member</td>
</tr>
<tr>
<td>Adult Mental Health Rehabilitation (AMHR)</td>
<td>A supervised residential group home that provides mental health services</td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td>A facility licensed by the Department of Health to provide apartment-style housing</td>
</tr>
<tr>
<td>Assisted Living Program</td>
<td>Assisted living service to tenants of certain publicly subsidized senior housing buildings</td>
</tr>
<tr>
<td>Behavioral Management – Traumatic Brain Injury (TBI) (Group and Individual)</td>
<td>Program provided in or out of the home designed to treat the member and caregivers when the member has a TBI diagnosis</td>
</tr>
<tr>
<td>Caregiver/Participant Training</td>
<td>Training for caregivers</td>
</tr>
<tr>
<td>Chore Services</td>
<td>Services needed to maintain the home in a clean and safe environment; not every day housekeeping tasks</td>
</tr>
<tr>
<td>Cognitive Therapy (Group and Individual)</td>
<td>Services to help support loss in function</td>
</tr>
<tr>
<td>Community Residential Services</td>
<td>Services that help support and provide supervision for members with a TBI diagnosis</td>
</tr>
<tr>
<td>Community Transition Services</td>
<td>Services provided to help move from an institutional setting into his/her own home in the community</td>
</tr>
<tr>
<td>Home-Based Supportive Care</td>
<td>Services that assist with household needs (e.g., meal preparation, laundry)</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>Prepared meals brought to your home</td>
</tr>
</tbody>
</table>

You have access to NJ FamilyCare benefits

What Horizon NJ Health Covers

<table>
<thead>
<tr>
<th>NJ FamilyCare Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology Services</td>
<td></td>
</tr>
<tr>
<td>(Diagnostic &amp; Therapeutic)</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation Services (Outpatient Physical Therapy, Cognitive Rehabilitation Therapy Occupational Therapy and Speech Pathology)</td>
<td>Covered</td>
</tr>
<tr>
<td>Sex Abuse Examinations and Related Diagnostic Testing</td>
<td>Covered by NJ FamilyCare Fee-for-Service</td>
</tr>
<tr>
<td>Specialty Foods</td>
<td></td>
</tr>
<tr>
<td>(Medical Foods)</td>
<td>Coverage is limited to nutritional supplements requiring medical supervision for members with inborn errors of metabolism and related genetic conditions. Medical foods and special diets for all other medical conditions are not covered.</td>
</tr>
<tr>
<td>Substance use</td>
<td></td>
</tr>
<tr>
<td>(Inpatient and Outpatient)</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation Services</td>
<td></td>
</tr>
<tr>
<td>- Emergency Ambulance (911)</td>
<td>Coverage is limited to medical emergencies only.</td>
</tr>
<tr>
<td>Transportation to Medically Necessary Services</td>
<td>Covered by NJ FamilyCare Fee-for-Service through LogistiCare. To schedule, call LogistiCare (State transportation contractor). NOTE: Members should call LogistiCare at 1-866-527-9933 (TTY 1-866-288-3133) to book a trip by 12:00 p.m. at least 48 hours in advance of a routine transportation need.</td>
</tr>
</tbody>
</table>

The following services may be available to you when assessed as a need and identified in your Plan of Care:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Partial Hospitalization (Mental Health)</td>
<td>Services that provide a non-residential psychiatric rehabilitation program for members with serious mental illness</td>
</tr>
<tr>
<td>Adult Family Care</td>
<td>Living in the home or apartment of a trained caregiver who provides support and services to the member</td>
</tr>
<tr>
<td>Adult Mental Health Rehabilitation (AMHR)</td>
<td>A supervised residential group home that provides mental health services</td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td>A facility licensed by the Department of Health to provide apartment-style housing</td>
</tr>
<tr>
<td>Assisted Living Program</td>
<td>Assisted living service to tenants of certain publicly subsidized senior housing buildings</td>
</tr>
<tr>
<td>Behavioral Management – Traumatic Brain Injury (TBI) (Group and Individual)</td>
<td>Program provided in or out of the home designed to treat the member and caregivers when the member has a TBI diagnosis</td>
</tr>
<tr>
<td>Caregiver/Participant Training</td>
<td>Training for caregivers</td>
</tr>
<tr>
<td>Chore Services</td>
<td>Services needed to maintain the home in a clean and safe environment; not every day housekeeping tasks</td>
</tr>
<tr>
<td>Cognitive Therapy (Group and Individual)</td>
<td>Services to help support loss in function</td>
</tr>
<tr>
<td>Community Residential Services</td>
<td>Services that help support and provide supervision for members with a TBI diagnosis</td>
</tr>
<tr>
<td>Community Transition Services</td>
<td>Services provided to help move from an institutional setting into his/her own home in the community</td>
</tr>
<tr>
<td>Home-Based Supportive Care</td>
<td>Services that assist with household needs (e.g., meal preparation, laundry)</td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td>Prepared meals brought to your home</td>
</tr>
</tbody>
</table>
The following services may be available to you when assessed as a need and identified in your Plan of Care: (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Psychiatric Hospital Care</td>
<td>Mental health care services that you get in a hospital that requires you to be admitted as an inpatient</td>
</tr>
<tr>
<td>Medication Dispensing Device</td>
<td>A device to help give medications and medication reminders</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>Transportation to gain access to community services and activities</td>
</tr>
<tr>
<td>Nursing Facility Services (Custodial)</td>
<td>Facility care with 24-hour medical supervision and continuous nursing care</td>
</tr>
<tr>
<td>Occupational Therapy (Group and Individual)</td>
<td>Services to help prevent loss of function</td>
</tr>
<tr>
<td>Opioid Treatment Services</td>
<td>Medication for maintenance and/or detoxification in combination with substance use disorder counseling in a licensed treatment facility</td>
</tr>
<tr>
<td>Outpatient Mental Health Clinic/ Hospital Services</td>
<td>Mental health services provided in a community setting for members with a psychiatric diagnosis</td>
</tr>
<tr>
<td>Partial Care Services</td>
<td>Non-residential recovery and clinical services to help individuals with severe mental illness get back into having a successful role in the community and avoid hospitalization and relapse (e.g., counseling, pre-vocational services)</td>
</tr>
<tr>
<td>Personal Emergency Response Systems</td>
<td>A device that allows a member to call for help in an emergency</td>
</tr>
<tr>
<td>Physical Therapy (Group and Individual)</td>
<td>Services to help prevent loss of function</td>
</tr>
<tr>
<td>Private Duty Nursing (Adult)</td>
<td>Medically necessary nursing services</td>
</tr>
<tr>
<td>Residential Modifications</td>
<td>Physical adaptations to a member’s private primary residence necessary to ensure health and safety (e.g., wheelchair ramp)</td>
</tr>
<tr>
<td>Respite (Daily and Hourly)</td>
<td>A benefit to give caregivers a rest</td>
</tr>
<tr>
<td>Social Adult Day Care</td>
<td>Community-based group program that provides health, social and related support services in a protective setting</td>
</tr>
</tbody>
</table>

The following services may be available to you when assessed as a need and identified in your Plan of Care: (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech, Language and Hearing Therapy (Group and Individual)</td>
<td>Services to help prevent loss of function</td>
</tr>
<tr>
<td>Structured Day Program</td>
<td>Structured day program to assist with the development, independence and community living skills of members</td>
</tr>
<tr>
<td>Supported Day Services</td>
<td>Activities directed at the development of productive activity patterns for members</td>
</tr>
<tr>
<td>Vehicle Modifications</td>
<td>Modifications to a member or family vehicle to allow greater independence</td>
</tr>
</tbody>
</table>
Your Benefits (continued)

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 covered under any other health insurance policy or other private or governmental health benefit system or third-party liability.
• Any service covered under any other insurance policy or other private or governmental health benefit system or third-party liability.
• Cosmetic services or surgery except when medically necessary and approved.
• Experimental procedures or procedures not accepted as being effective, including experimental organ transplants.
• 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).
• Respite care for more than 30 days per year.
• 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.
• Services in which health care records do not reflect the requirements of the procedure described or procedure code used by the provider.
• 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 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 NJ FamilyCare accepts.
• Services provided by an immediate relative or household member, unless being delivered under the Self Directed Program.
• Services provided by or in an institution run by the federal government, such as the Veterans Health Administration.
• Services provided or started while on active duty in the military.
• Services provided outside the United States and its territories.
• Services provided without charge. Programs offered free of charge through public or voluntary agencies should be used to the fullest extent possible.
• 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.

Dental services

Good oral health is important to your body’s overall health. You should visit your dentist at least twice a year for an oral exam and cleaning. Children should have their first visit with a dentist at age one or soon after the eruption of the first tooth. Be sure to complete all recommended treatment.

You do not need a referral from your PCP to see a dentist, and your dentist does not need prior authorization from Horizon NJ Health for routine dental care, such as cleanings, fillings and X-rays. Some dental services such as crowns, dentures and root canals may require prior authorization.

Ask your dentist about this requirement. If you need to make an appointment with a dental specialist, use the online provider directory for a list of participating dental specialists. No prior approval is necessary to see a dental specialist. Contact Member Services at 1-844-444-4410 (TTY 711) if you need to see a non-participating dental specialist.

Vision services

Members are covered for routine eye exams every one or two years based on their age and health. You do not need a referral from your PCP for routine eye care. If you need more exams during the year or you need to see a vision specialist, such as an ophthalmologist, you will need to get a referral from your PCP.

Members with diabetes can have an eye exam every year, which should include a dilated retinal eye exam (DRE).

Vision services are available only from participating Horizon NJ Health eye doctors. Check the Provider Directory for a list of eye doctors.

Laboratory services

LabCorp is the laboratory services provider for Horizon NJ Health members. Your doctor will give you a prescription for laboratory testing. Take that prescription and your Horizon NJ Health member ID card when you get lab work done.

You can use the Horizon NJ Health Provider Directory to find a LabCorp location near you. LabCorp also offers online appointment scheduling at all New Jersey Patient Service Centers. Visit LabCorp.com/PSC to find a location. Walk-in patients are also welcome.

Your doctor will give you your lab test results. Or, you can use LabCorp Patient, an online service, to download and print your test results on your own. Visit patient.labcorp.com to register. LabCorp will give your test results to your doctor before posting them to your online account.

Prescription services

Horizon NJ Health covers many medications that are offered to you at a low cost. These approved drugs make up our formulary. If your doctor wants to prescribe a drug that is not included in our formulary, he or she will need to call us to get prior authorization, or approval in advance. It is important that the medications you take are safe and effective. That is why Horizon NJ Health has a committee made up of practicing doctors and pharmacists who review and approve our formulary. Some medications are not covered under your pharmacy benefit and they include, but are not limited to, the following: fertility agents, weight loss drugs and erectile dysfunction medications. Certain over-the-counter (OTC) products are covered with a written prescription (for example, Loratadine, Alaway, Zaditor OTC, Omeprazole, Lansoprazole, smoking deterreants).

Words to Know

Ophthalmologist: A doctor who treats people with eye problems, eye diseases and does eye surgery

Prescription: An order written by a doctor for a drug, test or other health service

Formulary: A list of approved medicines that Horizon NJ Health covers
For members residing in a long-term care facility, OTC medications are generally provided by the institution, rather than Horizon NJ Health. Horizon NJ Health requires the use of generic medicine when available. If your doctor decides that you must have a medicine that is not in the formulary, including a brand-name medicine exception, he or she can ask for special permission for you to get the medicine. While you are waiting for a response, the pharmacy can provide a 72-hour supply of the medicine. The Horizon NJ Health Pharmacy department will work with your doctor to fulfill your prescription needs. If you have questions, call toll free 1-844-444-4410 (TTY 711).

You can have prescriptions filled at any participating pharmacy. For a list of pharmacies or to find the pharmacy nearest to you, call Member Services. Participating pharmacies are also listed in the Provider Directory and in the Doctor & Hospital Finder at horizonNJhealth.com.

The Approved Drug List (formulary) is updated quarterly and as changes are made or new medications are approved. The Approved Drug List is updated as of the date that formulary changes are put in place. Changes to this list are included in the member newsletter, which is mailed quarterly to all members. Covered pharmaceuticals, including those that require prior authorization, are listed on our website at horizonNJhealth.com, under the Member Support tab, click Resources, then click Covered Drugs. There is no copayment for your prescription drugs.

In general, Horizon NJ Health allows up to a 30-day supply for drugs. If you are currently in a long term care facility, there is generally a maximum of a 14-day drug supply eligibility. A supply of greater than 14 days is permitted for certain units of medication (for example, eye drops). If you live in a long term care facility, the use of institutional sized drug products, for example, insulin, will be utilized where available. The website also has information on pharmaceutical management procedures, including the formulary listing, policies and limitations. Limitations include quantity, plan, supply/fill, step therapy and age. Paper copies of the pharmaceutical management procedures are available by contacting the Pharmacy Department at 1-844-444-4410 (TTY 711).

Pharmacy Lock-In Program

Members who see different doctors may have many types of medicine prescribed to them. This can be dangerous. The Pharmacy Lock-In Program coordinates a member’s care between pharmacies and doctors. To make sure your pharmacy care is coordinated, you should use only one pharmacy to fill your prescriptions. This will let the pharmacist learn about your health and be better able to help you with your medicine needs. Members who use many pharmacies or doctors may be reviewed each month to make sure that they are getting the proper care. If it is decided that using only one pharmacy will help the member get better care, the member may be “locked-in” to one pharmacy. We will send letters to the member, pharmacy and doctor when a Pharmacy Lock-In program is needed.

Medical transportation

Horizon NJ Health will provide emergency ground or air transportation for MLTSS members.

All non-emergency medical transportation services will be provided by LogistiCare. If you need special services or transportation for your medical care, you can call LogistiCare at 1-866-527-9933 (TTY 1-866-288-3133). For livery service, such as car service to a medical appointment, etc., you can also call LogistiCare for reservations. There is a 20 mile limit for transportation to your provider, unless an authorization is provided for offices outside this radius. You should call by noon at least two days in advance of your transportation need. After your medical appointment is over, if you have not scheduled a pickup time, you or someone at the doctor’s office can call the Where’s My Ride phone number at 1-866-527-9933 (TTY 711) and request that transportation be sent to pick you up. The transportation provider will pick you up within 90 minutes.

To report any problems with your transportation, call LogistiCare at 1-866-333-1735. You may also visit the LogistiCare website at wecare.logisticare.com, where you can complete an online form. LogistiCare will respond to your issue.

Remember – do not call an ambulance for routine transportation.

Behavioral health services

Horizon Behavioral Health provides behavioral health benefits for members. You do not need a referral from your PCP to see a mental health or substance use disorder provider. If you need medication for mental health and/or substance use disorder, your mental health and/or substance use disorder provider can prescribe the medicine for you. Contact a behavioral health provider or inform your MLTSS Care Manager if you are experiencing the following:

- Constantly feeling sad
- Feelings of hopelessness or helplessness
- Trouble sleeping
- Poor appetite
- Loss of interest in things you once enjoyed
- Difficulty concentrating
- Irritability

Words to Know

Ambulatory surgical center: A site that provides surgical care but does not provide care overnight

Utilization management

Horizon NJ Health wants to make sure you receive the right care for your problem, in the right setting. To do this, we have a Utilization Management (UM) team that works in collaboration with your MLTSS Care Manager to ensure that you get timely, efficient and quality service from doctors, hospitals, dentists and other providers.

Horizon NJ Health helps with referrals to specialists, admissions, discharges and length of stay issues when a member is admitted to a hospital or ambulatory surgical center. We give doctors information about our care and disease management programs when necessary.

Most of all, we work with your PCP or specialist to ensure that you get the continuous care you need. Horizon NJ Health has special staff who can help you with UM questions. If you have questions about our UM process, please contact your MLTSS Care Manager or MLTSS Member Services at 1-844-444-4410 (TTY 711).
Programs for You

Horizon NJ Health helps members manage many health issues. Talk to your Care Manager for information about:

- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- HIV/AIDS
- Hypertension

If you are enrolled in any of our Disease Management programs and no longer wish to be, please call Member Services toll free at 1-844-444-4410 (TTY 711).

Family planning services

If you are interested in family planning and contraceptive services, including genetic testing and counseling, Horizon NJ Health can help you find the services you need and will tell you about doctors and clinics that are close to you. Remember to take your Horizon NJ Health member ID card when you go to your appointment. You can also get family planning and contraceptive services from other clinics and doctors who accept the NJ FamilyCare program but who are not in the Horizon NJ Health network. Use your Health Benefits Identification (HBID) Card if you visit them.

Horizon Healthy Journey

Horizon NJ Health understands that it may be hard to remember all of your health care recommendations and appointments. The Horizon Healthy Journey program is designed to keep you on track with reminders and educational materials relevant to your health care needs. We will contact you by phone with both live and automated calls. You will also receive materials by mail. Horizon NJ Health will work with your doctors to make sure they are aware of your recommended services.

Help for pregnant women: Mom’s GEMS (Getting Early Maternity Services)

If you think you are pregnant, call your MLTSS Care Manager right away for an appointment. Mom’s GEMS is designed to help you get good prenatal care, regular checkups, nutrition advice and postpartum information after your baby is born.

When you are pregnant, you should see your Ob/Gyn:

- At least once during the first two months, or once you know you are pregnant
- Every four weeks during the first six months
- Every two weeks during the seventh and eighth month
- Every week during the last month
- Between three weeks and two months after the birth of your baby for a postpartum visit

If you are pregnant or have children, you may be eligible for an extra program called WIC (Women, Infants and Children). This program gives you nutritional benefits, such as free milk, eggs and cheese. Your Care Manager will help you to apply and to set up an appointment.

Keeping children healthy

The Early Periodic Screening, Diagnostic and Treatment (EPSDT) program is a government mandate that helps keep children healthy. Horizon NJ Health has several programs to make sure children get all the EPSDT benefits.

Horizon NJ Health helps maintain the health of children from birth until they are 2 years old. This program helps keep immunizations and well-child visits on track and reminds parents to have their child’s PCP screen for medical problems early and continue to check for problems as the child grows.

Taking children to the doctor is very important for their healthy growth and development. Children need to go to the doctor several times a year up to age 2 and at least once a year from the ages of 2 to 20 years old. Babies should see their doctor at the following ages:

- Newborn – 3 days post hospital discharge
- Under 6 weeks
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- And once a year through age 20

During well-child visits, the doctor will check your child’s vision, teeth, hearing, nutrition, growth and development. The doctor will also give lead screenings to find out if your child has been exposed to dangerous levels of lead from paint or other sources. These visits are also a good time to ask questions and talk about any problems or concerns you have.

Your child should see a dentist for a first dental exam by age 1 or soon after the appearance of the first tooth, and afterwards at least twice yearly dental exams and cleanings. When your child is very young, these visits will include an oral exam, the application of fluoride varnish to the teeth to prevent cavities, risk assessment and anticipatory guidance to help you keep your child’s teeth healthy. Be sure to complete all recommended dental treatment.

Your child’s Horizon NJ Health doctor will give these checkups, treat problems and call in specialists if they are needed. Horizon NJ Health covers all of these services for members up to the age of 21.

Horizon NJ Health also covers prescription and non-prescription drugs, in-home ventilator services and private duty nursing for children when needed.

Remember that immunizations are safe and effective. By making sure your child is immunized, you can protect your child from serious illnesses, such as:

- Mumps
- Polio
- Rubella
- Chicken pox
- Influenza
- Rotavirus
- Hepatitis A
- Meningitis
- Diphtheria
- Tetanus
- Hepatitis B
- Pertussis
- Pneumococcal invasive disease

Be sure your children get these important immunizations before their second birthday.

Words to Know

Prenatal care: Care for pregnant women
Postpartum: Care for a woman after she delivers a baby
EPSDT: Stands for Early and Periodic Screening, Diagnostic and Treatment. This is a group of tests required for children up to age 21 to make sure they are getting appropriate care.
Test your child for lead poisoning

According to New Jersey state law, children must be tested for lead poisoning, first between 9 and 18 months old (preferably at 12 months) and again at 24 months. Any child who is 6 months of age or older and is exposed to a known or suspected lead hazard, should be tested. Children between the ages of 27 months and 6 years old should be tested if they were never tested before. Lead care management is given to all Horizon NJ Health members up to 6 years of age who have high blood lead levels. The lead program gives you information about keeping your home lead free and safe. You will get information on blood lead levels and preventive measures, including housekeeping, hygiene, appropriate nutrition and why it is so important that you follow your doctor's instructions when dealing with lead problems.

Lead can be found in places you don’t expect. Cooking tools, toys and candies imported from other countries may contain lead.

Smoking cessation

Being smoke-free is one of the best things you can do to improve your health. By quitting smoking, you can improve your lung function and circulation. You can also reduce your chance of developing certain cancers and heart disease, among many other benefits. It may help you add years to your life.

New Jersey has several support options to help you quit smoking:
- **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. The program supports 26 different languages 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.

The medicines listed below are available to Horizon NJ Health members and can help you quit smoking. Ask your doctor if any of these are right for you:
- Bupropion (Zyban)
- Nicotine transdermal patches (Nicoderm)
- Nicotine polacrilex gum (Nicorette)
- Nicotine polacrilex lozenge (Commit)

As a Horizon NJ Health member you have the right to:
- Get services no matter what your age, race, religion, color, creed, gender, national origin, ancestry, political beliefs, sexual or affection preference or orientation, health status, marital status or disability
- Be treated with respect, dignity and a right to privacy at all times
- Have access to care that has no communication or access barriers, including the assistance of a translator if needed
- Get medical care in a timely way and have access to a PCP or doctor who will help you. A PCP is the doctor you will see most of the time who will coordinate your care. He or she will be there for you, 24 hours a day, 365 days a year, if you need urgent care. This includes the right to:
  1. Choose your own doctor from the Horizon NJ Health list of doctors.
  2. Have a second opinion or a visit to a doctor for another point of view in certain cases.
  3. Be referred to a specialist who has experience treating your disability or health condition if you have a disability or condition that lasts a long time.
  4. Request a referral that you can use over again when you need to see a specialist for a medical condition that is long-lasting.
  5. Get care from a doctor who does not work with Horizon NJ Health when a Horizon NJ Health doctor is not available.

You have the right to:
- Have a choice of specialists. These are doctors who treat special illnesses or problems. This includes the right to:
  1. Get information about what you have to do to see a specialist. This is called the referral process.
  2. Have a second opinion or a visit to a doctor for another point of view in certain cases.
  3. Be referred to a specialist who has experience treating your disability or health condition if you have a disability or condition that lasts a long time.
  4. Request a referral that you can use over again when you need to see a specialist for a medical condition that is long-lasting.
  5. Get care from a doctor who does not work with Horizon NJ Health when a Horizon NJ Health doctor is not available.

You have the right to:
- Call 911 for what may be a life-threatening situation without letting Horizon NJ Health know before you do it. If you go to the ER, this includes the right to:
  1. Have Horizon NJ Health pay for a medical screening exam in the ER to see whether an emergency medical condition exists.
You have the right to:

- Certain coverage benefits after the birth of a child. This includes the right to:
  1. Stays in the hospital after you have had a baby that are no less than 48 hours for a normal vaginal delivery and no less than 96 hours after a cesarean section birth.
  2. Get up to 120 days of continued coverage, if it is medically necessary, from a doctor who no longer works with Horizon NJ Health, including:
    - Up to six months after surgery
    - Six weeks after childbirth
    - One year of psychological or oncologic (cancer) treatment
  No coverage may be continued if the doctor is let go from his or her job because they are a danger to their patients, has committed fraud or has been disciplined by the State Board of Medical Examiners.

You have the right to:

- Give instructions about your health care and name someone else to make health care decisions for you. This includes the right to:
  1. Make an advance directive about medical care. An advance directive is also known as a living will.

You have the right to:

- Ask questions and get answers and information about your health plan and anything you do not understand. You can also make suggestions. This includes the right to:
  1. Get timely notice of changes to your benefits or the status of your doctor.
  2. Offer suggestions for changes in policies, procedures and services. This can include your own rights and responsibilities.

3. Look at your medical records at no charge.
4. Be informed in writing if Horizon NJ Health decides to end your membership.
5. Tell Horizon NJ Health when you no longer want to be a member.

You have the right to:

- Appeal a decision, based on medical necessity, to deny or limit coverage your doctor recommends, first within Horizon NJ Health and then through an independent organization that can make a decision. An appeal is a request you make to Horizon NJ Health on decisions made about your care. This includes the right to:
  1. File a grievance about the organization or the care provided using your first language.
  2. Know that you or your doctor cannot be punished for filing a grievance or appeal against Horizon NJ Health. Also, you cannot be disenrolled as a member for filing a grievance or appeal against Horizon NJ Health.
  3. Contact the Department of Banking and Insurance or the Department of Human Services if you are not satisfied with Horizon NJ Health’s decision about a grievance or appeal.
  4. Use the Fair Hearing process if you are eligible.

Treatment of minors

Horizon NJ Health will provide care for members younger than 18 years old following all laws. Treatment will be at the request of the minor’s parent(s) or other person(s) who have legal responsibility for the minor’s medical care. You have the right to make informed decisions and allow treatment of your dependents who are minors, or under 18 years old.

In certain cases, New Jersey law allows minors to make health care decisions for themselves. Horizon NJ Health will allow treatment of minors when decisions are not made with their parent(s) or guardian(s) in the following cases:

- Minors who go to an ER for treatment because of an emergency medical condition
- Minors who want family planning services, maternity care or sexually transmitted diseases (STD) services
- Minors living on their own who have their own NJ FamilyCare or Health Benefits ID (HBID) card number as head of their household

As a member of Horizon NJ Health, you also have responsibilities. You are responsible for:

- Talking openly and honestly with your PCP or specialist when telling them about your health
- Seeking care regularly from a doctor to protect your health. This includes making appointments for routine checkups and shots.
- Giving information that is needed to a doctor and Horizon NJ Health so care can be provided to you
- Following your doctor’s advice that was agreed on and considering the results if you do not

- Keeping appointments and calling in advance if an appointment must be canceled
- Reading all Horizon NJ Health member materials and following the rules of membership
- Following the right steps when filing grievances about care
- Learning about health issues through education when it is offered
- Paying any copayments or premiums (the amount of money your health plan says you need to pay when getting care) when you have to do so
- Letting the Health Benefits coordinator and Horizon NJ Health know about any doctors you are seeing when you enroll in Horizon NJ Health

- Treatment of minors

Horizon NJ Health will provide care for members younger than 18 years old following all laws. Treatment will be at the request of the minor’s parent(s) or other person(s) who have legal responsibility for the minor’s medical care. You have the right to make informed decisions and allow treatment of your dependents who are minors, or under 18 years old.

In certain cases, New Jersey law allows minors to make health care decisions for themselves. Horizon NJ Health will allow treatment of minors when decisions are not made with their parent(s) or guardian(s) in the following cases:

- Minors who go to an ER for treatment because of an emergency medical condition
- Minors who want family planning services, maternity care or sexually transmitted diseases (STD) services
- Minors living on their own who have their own NJ FamilyCare or Health Benefits ID (HBID) card number as head of their household

As a member of Horizon NJ Health, you also have responsibilities. You are responsible for:

- Talking openly and honestly with your PCP or specialist when telling them about your health
- Seeking care regularly from a doctor to protect your health. This includes making appointments for routine checkups and shots.
- Giving information that is needed to a doctor and Horizon NJ Health so care can be provided to you
- Following your doctor’s advice that was agreed on and considering the results if you do not

- Keeping appointments and calling in advance if an appointment must be canceled
- Reading all Horizon NJ Health member materials and following the rules of membership
- Following the right steps when filing grievances about care
- Learning about health issues through education when it is offered
- Paying any copayments or premiums (the amount of money your health plan says you need to pay when getting care) when you have to do so
- Letting the Health Benefits coordinator and Horizon NJ Health know about any doctors you are seeing when you enroll in Horizon NJ Health
Horizon NJ Health evaluates and approves new technology, including reviewing guidelines from Horizon Healthcare of New Jersey, Inc., leading medical literature and published clinical guidelines and speaking with experts in specific areas, including practicing doctors. We do all of this to make sure that you are receiving the best possible health care.

If you would like a copy of the clinical or preventive guidelines that Horizon NJ Health follows, call Member Services at 1-844-444-4410, (TTY 711). The guidelines are also available on our website at horizonNJhealth.com/clinicalguidelines.

We value your opinion

Every few months, Horizon NJ Health hosts a community health advisory meeting with members, community health advocates and community leaders to talk about ways to improve member services, health education and member outreach activities. If you would like to join us at this meeting, call Horizon NJ Health’s Marketing Department at 1-844-444-4410 (TTY 711) or email communications@horizonNJhealth.com.

Member satisfaction survey results

Each year, Horizon NJ Health members are asked what things we and our doctors do well and what things could be done better. This is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. Answers to these questions help us improve the services that we provide. Results of the most recent member satisfaction survey are available on our website at horizonNJhealth.com or can be mailed to you by calling Member Services.

How your doctor is paid

Doctors in our network are paid by Horizon NJ Health in different ways. Your doctor may be paid each time he or she treats you (fee-for-service) or a doctor may be paid a set fee each month for each member whether or not the member actually gets services (capitation). Your doctor may also get a salary.

These payment methods can include financial reward agreements to pay some doctors more (bonuses) based on many things, such as member satisfaction, quality of care, control of costs and use of services. Financial incentives do not encourage decisions that result in providing fewer services. Horizon NJ Health does not reward providers for issuing denials of coverage.

Medical decision-making

Utilization Management (UM) decisions are made based on the member’s health care needs and benefits. Horizon NJ Health does not offer rewards or pay to those who make UM decisions. Horizon NJ Health does not offer any rewards or pay to its staff who handle the UM decisions for denials of coverage or services that are needed for good health. Horizon NJ Health does not stop doctors from discussing all treatment options with their patients, even if the service(s) is not a covered benefit.

Other Health Insurance

If you have coverage through another insurance plan, including Medicare, as well as Horizon NJ Health, your doctor must use the other insurance plan for payment before he or she bills Horizon NJ Health for your care. To be sure that the doctor bills the correct plan, show ALL of your insurance member ID cards when you go to the doctor. For more information please contact Member Services, your MLTSS Care Manager or visit NJ Division of Medical Assistance and Health Services at http://www.state.nj.us/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf.

When using benefits covered by the other insurance plan, follow the requirements of that plan. This includes the need for referrals or using network doctors.

<table>
<thead>
<tr>
<th>When You Have Both Medicare and NJ FamilyCare/Medicaid</th>
<th>Use This Type of Doctor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An approved, Medicare-covered benefit (for example: primary care, lab tests, specialists)</td>
<td>Use a Medicare doctor (does not need to be in the Horizon NJ Health network)</td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td>Use a Medicare hospital. If possible, use a hospital also in the Horizon NJ Health network</td>
</tr>
<tr>
<td>Emergency care received at a hospital emergency department</td>
<td>Go to the nearest hospital</td>
</tr>
<tr>
<td>A medically necessary service not covered by Medicare but covered by Horizon NJ Health (for example: dental services or hearing aids)</td>
<td>Use a Horizon NJ Health network doctor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When You Have Other Insurance and NJ FamilyCare/Medicaid</th>
<th>Use This Type of Doctor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An approved, covered benefit from the other insurance, including referrals from that insurance’s PCP, prescription drugs and inpatient hospital stays</td>
<td>Use a doctor from that insurance’s network (does not need to be in the Horizon NJ Health network)</td>
</tr>
<tr>
<td>A medically necessary service that may not be covered by the other insurance but is covered by Horizon NJ Health (for example: personal care assistance services, family planning services)</td>
<td>Use a Horizon NJ Health network doctor</td>
</tr>
</tbody>
</table>
The Horizon NJ Health Managed Long Term Services & Supports (MLTSS) program provides services and supports to adults and children to help them perform activities of daily living such as bathing, dressing, eating and toileting, as well as supportive activities such as making meals, shopping, cleaning and laundry. Eligibility for these services is based on multiple pieces of information, including how well a person can perform these basic life tasks. The State of New Jersey, Division of Aging Services, Office of Community Choice Options (OCCO), makes all final clinical eligibility decisions.

Horizon NJ Health members who are eligible for MLTSS will be assigned a dedicated Care Manager. The Care Manager, with your input, input from your caregiver and input from your PCP, will create a Plan of Care based on your care needs. Once the Plan of Care is completed, the Care Manager will arrange for service providers and for admission to a nursing facility or community residential setting if needed. The Care Manager will follow up with you to make sure that the services continue to meet your care needs.

Horizon NJ Health wishes to provide quality MLTSS that promote independence, dignity, and choice. Horizon NJ Health understands that many people want to stay in their homes as they get older or need help with everyday tasks to be on their own; some cannot afford to pay privately for this help and get most of their help from family, friends and neighbors. We refer to help from family, friends and neighbors as “informal support.” Horizon NJ Health’s MLTSS program is NOT intended to replace this valuable assistance but to make it easier for caregivers to remain in their critical role as the main support system.

At times, despite Horizon NJ Health’s and the member’s best efforts, it may no longer be safe for a member to remain in the community. In such situations, the Care Manager may recommend that the member be placed in a nursing facility or community residential setting.

Help from Member Services (1-844-444-4410)

Our multilingual Member Services staff is ready to help you get the most out of your Horizon NJ Health membership. You can call us anytime at 1-844-444-4410 (TTY 711). Your Care Manager will be available Monday through Friday, from 8 a.m. to 5 p.m., ET. At other times, you can call and leave a message for your Care Manager, or speak to the on-call care management staff available 24 hours a day, seven days a week. When leaving a message, please be sure to give enough detail for us to understand why you are calling. We will return your call within 24 hours.

Translation services and audio/visual information

We have staff members who can speak many languages. If you speak another language, our customer service representative can use the Language Line service, which has more than 100 languages and dialects. We can also arrange for a translator to talk over the phone with you and your doctor to help during your doctor’s visit. Horizon NJ Health can coordinate a sign language interpreter to be with you at the doctor’s office. Translators will make sure that your doctor knows what you are saying and you know what the doctor is saying. With the translator’s help, you can get answers to all of your questions.

There is no cost to you to use our translation or sign language interpreter services. To schedule these services, just call Member Services toll free at 1-844-444-4410 (TTY 711).

All Horizon NJ Health information for members is available in Spanish. If you need information printed in another language, call Member Services. Materials for the visually and hearing impaired are also available through Member Services.

Who qualifies for MLTSS?

To qualify for Horizon NJ Health’s Managed Long Term Services & Supports (MLTSS) program, you must meet all of the following standards:

- Be a resident of New Jersey
- Be 65 years old or older, or determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services.
- Qualify for NJ FamilyCare financial eligibility by:
  o Qualifying for SSI in the community, or
  o Qualifying for NJ FamilyCare Only - Institutional Level, or
  o Qualifying for New Jersey Care (with income at or below 100% of the Federal Poverty Level and resources at or below $2,000).
- Meet clinical eligibility, which is determined by the New Jersey Office of Community Choice Options (OCCO).
- Want to enroll and receive services in a nursing home or in a community setting instead of living in a nursing home.

To enroll in NJ FamilyCare MLTSS, contact your local County Welfare Agency (Board of Social Services) or your local County Agency on Aging (AAA) – Aging and Disability Resource Connection (ADRC). OCCO makes the final decisions about enrollment into the MLTSS program.

Keeping your membership

Once enrolled in the MLTSS program, you will remain enrolled if you remain eligible, follow all the program rules, and your needs and general health and welfare can be addressed by the MLTSS program.

If you have NJ FamilyCare, you must renew your eligibility every year. If you don’t renew your NJ FamilyCare eligibility on time, you might have to start over as a new applicant, and this approval process will take longer.

You can call NJ FamilyCare at 1-800-701-0710 (TTY 1-800-701-0720) to find out your renewal date or ask for a renewal form. You can also contact your caseworker at your County Welfare Agency (CWA). To find the location and phone number of your county CWA, you can call the NJ FamilyCare hotline toll free at 1-800-356-1561 (TTY 711) NJ FamilyCare members who are Aged, Blind and Disabled (ABD) cannot fill out a renewal application online.
You have the right to:

1. Ask for and receive information on the choice of services and providers available to you.
2. Have access to and choice of qualified service providers.
3. Be told about all of your rights before receiving chosen and approved services.
4. Get services no matter what your race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status or disability.
5. Have access to all services that are best for your health and welfare.
6. Make your own decisions after being assisted to understand the risks and possible effects of the decisions made.
7. Make decisions about care.
8. Help develop and change your own plan of care.
9. Ask for changes in services at any time, including to add, increase, decrease or discontinue them.
10. Ask for and receive from your Care Manager a list of names and duties of any people assigned to provide services to you under the plan of care.
11. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers.
12. Be told about a list of resident rights, and receive a copy in writing, upon admission to an institution or community residential setting.
13. Be told of all the covered/required services you are entitled to, required by and/or offered by the institutional or residential setting, and of any charges not covered by Horizon NJ Health while in the facility.
14. Not to be discharged or transferred out of a facility unless it is medically necessary; to protect your welfare and safety as well as the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice, to pay the facility from available income as reported on the statement of available income for NJ FamilyCare payment.
15. Have Horizon NJ Health protect and promote all your rights that are outlined in this document.
16. Have all rights and responsibilities outlined here shared with your authorized representative or court-appointed legal guardian.

Along with rights come responsibilities. Here are some of the key responsibilities for MLTSS members:

1. Provide all health and treatment-related information, including but not limited to, medication, circumstances, living arrangements, and informal and formal supports, to the Care Manager to identify care needs and develop a Plan of Care.
2. Understand your health care needs and work with your Care Manager to develop or change goals and services.
3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and delivery of services.
4. Ask questions when you need more information.
5. Understand the risks that come with your decisions about care.
6. Develop an emergency backup plan for care and services with your Care Manager.
7. Report any major changes about your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager.
8. Notify your Care Manager should any problems occur or if you are not pleased with the services being provided.
9. Pay your room and board in a nursing facility or community residential setting and your cost share on time each month (if applicable).
10. Treat service workers and care providers with dignity and respect.
11. Keep all Horizon NJ Health documents, such as your Plan of Care, emergency backup plan, etc., for your personal records and future reference.
12. Follow Horizon NJ Health’s rules and/or those rules of institutional or community residential settings.

MLTSS Care Management

Horizon NJ Health provides every Managed Long Term Services & Supports (MLTSS) member with a Care Manager and care management team. The Care Manager leads the team. Your Care Manager is a health care professional, generally a nurse or a social worker. The care management team includes Nurses, Social Workers and a clinical support coordinator to help with your daily needs.

The MLTSS Care Manager will visit you in your home and talk to you about your needs. Together, you will develop your Plan of Care. Your Plan of Care is based on your health status and health care needs. Horizon NJ Health will also get input from your family, caregivers and others you think are important for us to talk with. The care plan will list the services you will get from Horizon NJ Health and describe the services that Horizon NJ Health will schedule for you. Your care plan is important. It shows we have all worked together to decide how we will help you. The goal of the care plan is to help you get and stay as healthy as you can be to keep your independence and stay in your community.

After your care plan is developed, your care team will help you get all the care and services you need. The care management team will work with you to make appointments. Your Care Manager will call you regularly and will also come to your home to assess your needs and services, and to review and update your care plan. You will always have your Care Manager’s phone number. If you leave a message for your Care Manager, he or she will return your call within one business day. If your Care Manager is unavailable, you can call to talk to the clinical care coordinator for help at any time. If you need help after work hours or on weekends, your call will be sent to someone who can help you right away.
Managed Long Term Services & Supports Program (continued)

Horizon NJ Health ensures that its MLTSS Care Managers work in a conflict-free environment. This means that Care Managers cannot work directly with their family members who are blood relatives or related by marriage. They also cannot be a direct-paid caregiver or be financially responsible for or empowered to make financial or health-related decisions on behalf of a member they are assigned to. Your Horizon NJ Health MLTSS Care Manager will call you to introduce him/herself when you join. You have the right to change your Care Manager. You may do so by telling your Care Manager or calling Member Services at 1-844-444-4410 (TTY 711).

For example, if you need to know where to go for urgent care, your call will be sent to the on-call staff. If that happens, your Care Manager will get information about your call to be sure you got what you needed. Services will be provided to you within 45 calendar days of your enrollment, except for residential modification and vehicle modification. Your care management team will help coordinate your care, such as physician visits, prescription drugs, behavioral health care, applying for services and coordinating other health providers. You can participate in your care by sharing your needs and concerns with your care management team so you may continue to live independently in your community.

You and your care management team will review your care plan at least every 90 calendar days if you are living in your own private home or in a pediatric specialty care nursing facility (SCNF). You and your care management team will review your care plan at least every 180 calendar days if you are living in a Nursing Facility, non-pediatric SCNF or a Community Alternative Residential Services (CARS) setting. The care team may also review your care plan if your condition changes. Horizon NJ Health members must use in-network, contracted providers to get covered MLTSS services.

What is a Plan of Care?

The Plan of Care is based on your assessed care needs. It outlines what services and supports are needed to help you. Your Plan of Care is personalized for you.

The Plan of Care form and the tools and methods used to support and develop it help make sure you are getting comprehensive and cost-effective delivery of services. The Plan of Care is reviewed often and updated at least every year to ensure you get the services you need.

The Plan of Care will be signed and dated by you and/or your authorized representative and you will get a copy within 45 days. You will be told about any changes to the Plan of Care and you must state if you agree or disagree with the following statements:

- I agree with the Plan of Care.
- I had the freedom to choose the services in the Plan of Care.
- I had the freedom to choose the providers of my services based on available providers.
- I helped develop this Plan of Care.
- I am aware of my rights and responsibilities as a member of this program.
- I am aware that the services outlined in this Plan of Care are not guaranteed.
- I have been told about potential risk factors outlined in this Plan of Care.
- I understand and accept these potential risk factors.
- I understand and accept that a backup plan will be initiated as stated in my Plan of Care.
- I understand that I may appeal or request a Fair Hearing for the reduction or denial of services after I receive the Horizon NJ Health decision letter from the Internal Appeal.

The Plan of Care will be developed with you and/or your authorized representative, based on your needs. The plan will include unmet needs, personal goals, risk factors, and backup plans. If you disagree with any of these statements, your concerns will be noted on the plan before you sign it. You must review and sign off on any changes to your Plan of Care.

Your Care Manager will also explain and sometimes remind you that specific clinical and financial criteria are required to participate in this program. They will tell you who is responsible for making sure you continue to be eligible for both.

Participant direction and Personal Preference Program

The Managed Long Term Services & Supports (MLTSS) program was designed to give you the most possible responsibility and independence so you have more control over making decisions, planning and managing your care. You can choose who provides your care, what type of care you want and need, when you want care, and where the care will be provided.

Caregivers or service providers become accountable to you. For those members who are capable of and choose to direct their own care, you may do so under the Personal Preference Program (PPP).

Members who participate in the Participant Direction of Home and Community-Based Services choose either to serve as the employer of record of their workers or to name a representative to serve as employer of record on his/her behalf.
Your Plan of Care (continued)

As the employer of record, you and/or your representative are responsible for:

1. Recruiting, hiring and firing workers
2. Determining workers’ duties and creating job descriptions
3. Scheduling workers
4. Supervising workers
5. Evaluating worker performance and addressing any faults or concerns
6. Setting the wage to be paid to each worker within the boundaries of the plan of care funds
7. Training workers to provide personalized care based on your needs and preferences
8. Ensuring that workers deliver only those services authorized, and reviewing and approving hours of workers
9. Reviewing and ensuring documentation for services provided
10. Developing and implementing as needed a backup plan to address instances when a scheduled worker is not available or does not show up as scheduled

You or your guardian may designate a representative to take over the participant direction responsibilities on your behalf. The representative must:

1. Be at least 18 years of age
2. Understand your support needs
3. Know your daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses
4. Be physically present in your residence on a regular basis or at least often enough to supervise and evaluate each worker

Your representative may not be paid for serving in this role and may not serve as your worker for any participant-directed service.

You may change your representative at any time. Contact your assigned Care Manager and the Participant Directed Program agency right away if you would like to change representatives.

If Participation Direction and PPP is something you are interested in, your Care Manager can tell you more about the program.

Health care appointments

Tell your care management team about your medical appointments. You should tell your Care Manager about what happened at your appointment. Include information about any changes to your medications or services. If you are unsure about what happened, tell your care management team. Your Care Manager will help you understand what happened. Your Care Manager will also help you include any new information in your care plan.

Bills

You should not get a bill from Horizon NJ Health network providers for covered services. You do not have to pay a network provider for covered services even if Horizon NJ Health denies payment to them. If we do not pay for all or part of a covered service, the provider is NOT allowed to bill you for what we did not pay.

The only time you should get a bill from a doctor is when you have:

- Been treated for a service not covered by Horizon NJ Health
- Sought care from a non-participating doctor without a referral or authorization from Horizon NJ Health.
- Received a service not covered by the NJ FamilyCare program

In these cases, you will be responsible to pay the entire cost of the service and must make payment arrangements directly with the doctor or provider.

If you receive a bill for any covered medical service, call your Care Manager or Member Services about the bill. Member Services may ask you to send the bill to:

Horizon NJ Health
Member/Provider Correspondence
PO Box 24077
Newark, NJ, 07101-0406

Medicaid benefits received after the age of 55 may be reimbursable to the State of New Jersey from the member’s estate. The recovery may include premium payments made on behalf of the beneficiary.

MLTSS services

Covered services are services Horizon NJ Health will pay for because you are a member. These services should be provided by a network provider. The exact service(s) you receive and how often and how long you get them is based on your medical condition(s) and health and social needs. You can get covered services as long as they are medically necessary. A service is medically necessary if it is needed to prevent, diagnose, correct or cure conditions that may cause acute suffering, endanger life, result in illness, interfere with your capacity for normal activity, or threaten some serious handicap.

The care plan you develop with your Care Manager will help make sure you get what you need. Sometimes Horizon NJ Health may need to review your request before you get a service. We may ask your PCP for an order or referral. This is to make sure you get the right care at the right place when you need it.

You will be able to get the care and services you need by calling your care management team. The services you need will be put on your care plan. Most of the time, your Care Manager will know what you need by just talking to you. You may always ask for a service you think may help you take better care of yourself.

Members must need and receive at least one MLTSS service monthly to remain in the program, as well as meet all other requirements listed in the Eligibility section, Who Qualifies for MLTSS, on page 34.

Your assigned Care Manager can give you a detailed description of each MLTSS service. Your Care Manager will also explain that there are limits on the amount, frequency and length of time of some services. Before services can begin, your Care Manager must approve and arrange the services.

MLTSS services are subject to limitations; your Care Manager can give you more information on these restrictions. Here is a list of limitations that apply to all MLTSS services:

- Services must be cost-effective, while supporting your care needs.
- Services are designed to supplement, not replace, assistance already being provided by family, friends and neighbors.
- Services are for the MLTSS member, NOT other household members.
- Services are requested according to the plan of care but cannot be guaranteed.
- MLTSS cannot be used to pay for what is already being paid for privately, through another program, or through another insurance plan.

If any changes are made to your benefits, Horizon NJ Health or the State of New Jersey will notify you of the change within 30 days.

If you get a bill
Do not ignore it; call Member Services for instructions and we will help you.
How do I get these services?
To obtain any covered services listed above, talk to your Care Manager. Your Care Manager will be able to review and approve most services you need. When you are approved to receive services, we will pay for you to receive the services for a period of time. If we think that you need more or fewer services, your Care Manager will talk to you about your needs. After that discussion and with your agreement, we may change the amount or type of services you are receiving to keep you independent in the community. Your care plan — with your input — will be updated to reflect these changes.

Who provides these services?
Services, as authorized and arranged by your assigned Care Manager, may only be given by approved, contracted providers with Horizon NJ Health. All service providers must meet qualification requirements determined by the State of New Jersey, approved by the federal government (if applicable), and credentialed by Horizon NJ Health.

Reporting abuse, neglect or exploitation
You have the right to be free from exploitation, fraud and abuse. Professionals, including care takers, are required to report suspected abuse, neglect or exploitation of any:
• Child or adult who resides in a community
• Elderly living in nursing homes or other long term care facilities, such as assisted living communities, nursing homes, assisted living residences, comprehensive personal care homes, adult medical day care, and other licensed acute and long term care facilities.

If you believe you are the subject of abuse, neglect or exploitation, report it immediately to your Care Manager and the appropriate source outlined below:

Adult Protective Services
The New Jersey Adult Protective Services (APS) program has offices in each of the 21 counties. Reports may be made to those County APS offices or to:
• The Public Awareness, Information, Assistance & Outreach Unit
24-Hour Toll-Free Hotline: 1-800-792-8820 (TTY 711)

Child Protective Services
The New Jersey Division of Child Protection and Permanency (DCPP) handles all reports of child abuse and neglect, including those occurring in institutional settings such as child care centers, schools, foster homes and residential treatment centers. These must be reported to the State Central Registry (SCR).
Child Abuse Hotline (SCR)
24-Hour Toll-Free Hotline: 1-877-NJ-ABUSE (1-877-652-2873) (TTY 1-800-835-5510)

Facility-Based Complaints and Investigation
Office of the Ombudsman for the Institutionalized Elderly investigates claims of abuse and neglect of people age 60 and older living in nursing homes and other long term health care facilities, such as assisted living facilities.
24-Hour Toll-Free Hotline: 1-877-582-6995
Email: ombudsman@advocate.state.nj.us
Write: The Office of the Ombudsman
PO Box 852
Trenton, NJ 08625-0852
Fax: 1-609-943-3479

Advance Directive
An advance directive is a legal document you can complete on your own that can help ensure your preferences for various medical treatments are followed if you become unable to make your own health care decisions. Your advance directive only goes into effect if your physician has evaluated you and determined that you are unable to understand your diagnosis, treatment options or the possible benefits and harms of the treatment options.

New Jersey has two kinds of advance directives — a “proxy directive” and an “instruction directive.” It is your decision whether to have both kinds or just one of them. You can find more information online at: www.state.nj.us/health/advancedirective/whatis.shtml.

Proxy Directive (Durable Power of Attorney for Health Care)
A proxy directive is a document you use to appoint a person to make health care decisions for you in the event you become unable to make them yourself. This document goes into effect whether your inability to make health care decisions is temporary because of an accident or permanent because of a disease. The person you appoint is known as your “health care representative” and they are responsible for making the same decisions you would have made under the circumstances. If they are unable to determine what you would want in a specific situation, they are to base their decision on what they think is in your best interest.

Instruction Directive (Living Will)
An instruction directive is a document you use to tell your physician and family about the kinds of situations in which you would want or not want life-sustaining treatment in the event you are unable to make your own health care decisions. You can also include a description of your beliefs, values and general care and treatment preferences. This will guide your physician and family when they have to make health care decisions for you in situations not specifically covered by your advance directive.

Plan ahead for emergencies
The first line of defense against the effects of a disaster is to make sure you are prepared. During a State or National emergency, the government and other agencies may not be able to meet your needs. It is important for you to create your own emergency plan and prepare for your own care and safety in an emergency.

The NJ Office of Emergency Management has a website for residents of New Jersey with special needs and their families to register. The information will allow emergency responders to better serve them in a disaster or other emergency. https://www13.state.nj.us/SpecialNeeds/signin.aspx

If you would like to register and need assistance, your MLTSS Care Manager can assist you.
Privacy and confidentiality

It is the policy of Horizon NJ Health to protect your confidentiality and that of your family. To protect this confidentiality:

- All information in your member record is confidential. Horizon NJ Health’s staff protects against accidental release of information by safeguarding records and reports from unauthorized use.
- All requests for information will be reviewed by the Horizon NJ Health Compliance Officer to protect your right to privacy. Only necessary information will be shared with community agencies, hospitals, long-term care facilities, and other providers to ensure the continuity and coordination of your care.
- Horizon NJ Health will permit only legally authorized representatives of Horizon NJ Health to inspect and request copies of your medical record and other records of the covered services provided to you according to the written consent you will have been asked to execute authorizing Horizon NJ Health to release such information.
- Horizon NJ Health will follow all federal and New Jersey state laws regarding confidentiality, including those that relate to HIV testing results.
- Horizon NJ Health will maintain all records relating to you for a period of not less than seven years after your disenrollment. Horizon NJ Health medical and financial records are, and will remain, the property of Horizon NJ Health except in accordance with applicable state and federal law, regulations, and Horizon NJ Health policy and procedures.
- Any requests for information received from law enforcement agencies regarding your care, such as from the police or district attorney’s office, will be brought to the attention of Horizon NJ Health legal counsel prior to providing any information to ensure that the proper authorization is obtained when the law requires it.

Fraud, waste and abuse

It is very important that you take personal responsibility for your health care and the costs of your care. Make sure you know as much as possible about the doctors you use and the treatments they provide.

Billions of dollars are lost to healthcare fraud, waste and abuse each year. That means money is paid for services that may never have been given. It could also mean that the service that was billed was not the one performed. Fraud, waste and abuse by doctors and members threaten our health care system and can victimize consumers.

What is fraud, waste and abuse?

Fraud and abuse happen when someone knowingly gives false information that lets someone get a benefit they are not entitled to.

Examples of Doctor fraud, waste and abuse

- Billing members for covered services (other than your copayments)
- Offering gifts or money for services
- Offering free services or supplies to use your Horizon NJ Health ID card number
- Giving services you do not need
- Abuse by medical staff

Examples of Member fraud, waste and abuse

- Selling or lending your Horizon NJ Health ID card to someone else
- Trying to get drugs or services you do not need
- Forging or changing prescriptions.

Misuse of your Horizon NJ Health ID card could result in you losing eligibility for health care services. Fraud and abuse are also crimes punishable by legal action with possible time in jail.

If you or someone you know is aware of health care fraud, waste and abuse, you should immediately report it to Horizon NJ Health’s Fraud Hotline at 1-855-FRAUD20 (1-855-372-8320, TTY 711), or the New Jersey Medicaid Fraud Division at 1-888-937-2835 (TTY 1-877-294-4356).

When making a report, please be clear about which person you believe is committing the fraud, tell us dates of service or items in question, and describe in as much detail as possible why you believe fraud may have been committed. If possible, please include your name, telephone number and address so we can contact you if we have questions during the investigation.

Any information you give us will be treated with strict confidentiality and no medical information will be released without lawful authorization. When reporting suspected insurance fraud, you do not have to give your contact information. If you decide to give your contact information, we will try to keep it confidential as much as legally possible.

Estate recovery

This is to remind you that the Division of Medical Assistance and Health Services (DMAHS) has the authority to file a claim and lien against the estate of a deceased Medicaid client or former client to recover all Medicaid payments for services received by that client on or after age 55. Your estate may be required to pay back DMAHS for those benefits.

The amount that DMAHS may recover includes, but is not limited to, all capitation payments to any managed care organization or transportation broker, regardless of whether any services were received from an individual or entity that was reimbursed by the managed care organization or transportation broker. DMAHS may recover these amounts when there is no surviving spouse, no surviving children under the age of 21, no surviving children of any age who are blind, and no surviving children of any age who are permanently and totally disabled as determined by the Social Security Administration. This information was previously provided to you when you applied for NJ FamilyCare.

To learn more, visit state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf.

Change of information

It is very important that we have your correct information. If not, your Horizon NJ Health Care Manager or clinical care coordinator may not be able to contact you. If you change your address or phone number, you must call Member Services at 1-844-444-4410 (TTY 711), your Care Manager or the clinical care coordinator.

You also must contact your County Welfare Agency (CWA) to let them know about the change. If not, you may not get important notices regarding your NJ FamilyCare coverage and annual renewal.
Ending your membership

The following are reasons you can be disenrolled from Horizon NJ Health’s MLTSS program:

- You are no longer enrolled with Horizon NJ Health
- You no longer meet financial or clinical eligibility criteria for long term level of care
- You will not allow the Department of Human Services staff or its designee to complete the clinical eligibility assessment
- You relocate to an unapproved licensed residence/setting
- You move out of New Jersey
- You are incarcerated
- You were transferred/enrolled into another waiver program or the State’s Program of All Inclusive Care for the Elderly (PACE)
- You refuse to pay your room and board and/or patient payment liability
- You no longer need the services offered in the MLTSS program
- You have not received services and/or cannot be contacted or located at the last known address
- You refuse services that are outlined in your plan of care and you refuse to voluntarily withdraw
- You fail to act in accordance with the rules governing involvement in the program

If you are disenrolled from the program, you will be told the reason and about any rights you may have to appeal the disenrollment.

You can choose to end your membership

Being a Horizon NJ Health member is your choice.

NJ FamilyCare members may end their membership without cause during the first 90 days after the date of enrollment or notice of enrollment (whichever happened later), and then every 12 months during the Open Enrollment Period. The State’s Open Enrollment Period occurs between October 1 and November 15 each year.

Members may leave Horizon NJ Health for good cause at any time.

As an NJ FamilyCare MLTSS member, you must choose another health plan before your membership ends. Once you ask to be disenrolled, it will take about 30 to 45 days from the date you ask until the time you are enrolled in the new health plan you select.

During this time, Horizon NJ Health will continue to provide your health care services. This includes transferring to another Managed Care Organization (MCO).

If you choose to voluntarily withdraw from the MLTSS program, your Care Manager will hold a face-to-face meeting with you to discuss your options for care. You will be given a Voluntary Withdrawal Form to sign. This decision to leave the MLTSS program does not necessarily mean that you will no longer have NJ FamilyCare benefits. OCCO will work with you if your decision to leave the program results in the loss of NJ FamilyCare due to your financial standings.

If you lose eligibility, you will be disenrolled from Horizon NJ Health. If you get your eligibility back within 60 days, you will be re-enrolled in Horizon NJ Health. If you become eligible again after 60 days, you may be enrolled in a different MCO if you do not select Horizon NJ Health or if Horizon NJ Health cannot accept any more members in your county.

When you leave Horizon NJ Health

- When you leave Horizon NJ Health, you will need to sign your enrollment application to allow us to send your medical records to your new health plan.
- Destroy your Horizon NJ Health ID card. It is very important that you protect your privacy by destroying the old cards so no one can steal your identity or your benefits.
- It will take 30 to 45 days between when you ask to leave and the date your enrollment with Horizon NJ Health ends. Horizon NJ Health or the State will continue to provide services until the disenrollment date.
- If you decide to disenroll voluntarily from Horizon NJ Health, you can list your reasons for leaving in writing.
- Enrollment and disenrollment are always subject to verification and approval by New Jersey DMAHSS.
- If your enrollment with Horizon NJ Health ends before an approved dental service has been completed, Horizon NJ Health will cover the service until completion, unless there is a change in the treatment plan by the treating dentist.

MLTSS Member Advocate

Horizon NJ Health cares about making sure that members in the MLTSS program have the information they need to make informed decisions and have someone they can speak to if they have any issues or questions. Every MLTSS member will be assigned a Care Manager and there is also a MLTSS Member Advocate available to you.

The MLTSS Member Advocate is responsible for:
- Participating in Interdisciplinary Team (IDT) meetings and reviewing with the member, as needed, the IDT process.
- Interacting with members to provide additional support, education and clarification regarding the MLTSS program and what services are available.
- Encouraging members to be fully informed of their Rights and Responsibilities.
- Assisting members with information needed in filing grievances and appeals as warranted.
- Supporting members in navigating Horizon NJ Health’s MLTSS program.

You can reach the Member Advocate Monday through Friday from 8:30 a.m. to 5 p.m. by calling 1-844-444-4410 (TTY 711).

Residence options

The MLTSS program helps qualified members get care in the most cost-effective, integrated and least restrictive environment that allows your needs to be met while feeling safe and secure with life, including your health and well-being. You may get services in various settings based on your desires, the cost of the services and the safest environment.

For members who meet program requirements, you have a right to choose between living in a nursing facility or in a home and community-based setting. You cannot be moved out of a nursing facility and into the community unless you agree to be moved. If you choose to live in a home and community-based setting, your needs must be met safely and cost effectively in the community. Your assigned Care Manager will evaluate the cost effectiveness of the Plan of Care if you receive home and community-based services in your community home. The cost of your plan of care is limited and must not be more than the rate set by the state.
Your Plan of Care (continued)

Patient Payment Liability

Members living in or placed in a nursing facility may have to pay Patient Payment Liability. The Patient Payment Liability for Cost of Care is that portion of the cost of care that nursing facility and assisted living residents must pay based on their income as determined by the County Welfare Agency.

Members pay this amount directly to the facility every month. You must pay your Patient Payment Liability to remain eligible for the MLTSS program. Your Care Manager can tell you about any Patient Payment Liability you will owe to the facility.

Members living in a Community Residential Setting (CRS), also known as a Traumatic Brain Injury (TBI) group home, will be advised by the provider about the amount they will need to pay. This amount is usually equal to 75 percent of the member's income.

Individuals who are living or placed in an assisted living residence must pay room and board payments and may have to pay Patient Payment Liability as well. These payments are paid directly to the facility every month.

You must pay your Patient Payment Liability to remain eligible for the MLTSS program. Your Care Manager can tell you about any Patient Payment Liability you will owe to the facility.

Nursing facility to community transition

If you live in a nursing facility, you may want to move out of the facility and into the community. Your assigned Care Manager will work with you to assess the ability to move you out of the nursing facility and back into a community setting. Your Care Manager will create a plan of care needed for your expected services to live in the community. The cost of your plan of care in the community is limited and must not be more than the rate set by the state.

If it is determined that you can safely and cost-effectively move from the nursing facility back to the community, you may be able to use the Community Transition Services benefit. This service aids in the transition from an institutional setting to your own home in the community by covering transitional expenses. This benefit can only be used one time and has a limit of $5,000. Allowable expenses are those needed for a person to establish a basic household that do not constitute room and board and may include, but are not limited to:

- Security deposits required to get a lease on an apartment or home
- Necessary household furnishings including furniture, kitchen items, food preparation items and bed/bath linens

Community Transition Services does NOT include items such as:

- Payment for room and board
- Monthly rental or mortgage expenses
- Recurring expenses such as food and regular utility charges

Services must be reasonable and necessary as determined through the plan of care process developed by you and your Care Manager. Services must also be based on need. You must have no other way to obtain these services yourself or from any other sources, including community resources.

Your Care Manager can give you more information about this benefit and help coordinate these services during the transition.

Horizon NJ Health has a grievance procedure for resolving disagreements between members, providers and/or Horizon NJ Health's operation or any cause of member dissatisfaction. Issues regarding emergency care will be addressed immediately. Issues regarding urgent care will be addressed within 48 hours in your primary language. Horizon NJ Health will not discriminate against a member or attempt to disenroll a member for filing a grievance or appeal.

Grievance procedure

A grievance, by phone or in writing, can usually be resolved by contacting Member Services. If you have a grievance, call 1-844-444-4410 (TTY 711) to talk about it with one of our Member Services representatives. If you want, you may send a written grievance to:

Horizon NJ Health
Attn: Member Grievances
1700 American Blvd.
Pennington, NJ 08534

A dental grievance can be filed by calling 1-855-878-5371 (TTY 1-800-508-6975). The Dental Operations group will handle all dental grievances and send you a letter with the outcome.

When we receive your call or letter, the following steps will occur:

1. A Member Services representative will be available to discuss and resolve your grievance. If you submit a grievance by mail, a Member Services representative will try to contact you by telephone within 24 hours of receipt of the grievance to discuss and resolve your grievance. The representative will document all the information discussed with you on an electronic form.

2. If you are not satisfied with the resolution from the Member Services representative, tell the representative and the grievance will be forwarded to Horizon NJ Health's grievance coordinator for further investigation.

3. The grievance coordinator will investigate the grievance and you will get written notification about the outcome within 30 days of receipt of the grievance.

Appeals

You or your doctor (with your written approval) have the right to ask Horizon NJ Health to review and change our decision if we have denied or reduced your benefits. This is called an appeal. An appeal can be oral or written. Oral appeals must be followed up with a written request. All appeals must be submitted within 60 days of the date of the denial determination. Please follow the appeal process described below.

You also have the right to ask the State to review Horizon NJ Health's decision about your service. This is called a Fair Hearing. You may request a Fair Hearing after the completion of your Internal Appeal. However, you must request a Fair Hearing within 120 days of the date of the decision letter from the Internal Appeal.

Injury (TBI) group home, will be advised by the

Appeal process

The appeal process has both an Internal and External process. The Internal Appeal process is completed by Horizon NJ Health. If you are not happy with our decision at the end of the Internal Appeal, or if Horizon NJ Health's decision was not made by the deadline set, you may ask to have your request reviewed by someone outside of Horizon NJ Health. This is an External Appeal.

During the appeal process, you have the right to continue to get the Horizon NJ Health service in question until the end of the process if:

- Your appeal is filed in a timely fashion
- The service was previously approved by Horizon NJ Health
- The service was ordered by an authorized provider...
Grievance and Appeal Procedures (continued)

• The appeal request is made on or before the final day of the previously approved authorization or within 10 calendar days of the notification of adverse benefit determination, whichever is later. In the event that Horizon NJ Health fails to meet its obligation to send the notification of adverse benefit determination at least 10 calendar days prior to the final day of the previously approved authorization, Horizon NJ Health shall automatically extend the authorization to a date 10 calendar days after the date on which the notification was sent. You may ask for a copy of the benefit provision, guideline, protocol or other criterion on which the appeal decision was based. Horizon NJ Health will provide the medical records relating to the determination.

Internal Appeal
You must request your Internal Appeal no later than 60 days after the date of the denial letter sent to you. You or your doctor must:
- Call Horizon NJ Health toll free at 1-844-444-4410 (TTY 711). Verbal requests must be followed up in writing, OR
- Fax your letter to the Appeals Department at 1-609-583-3028, OR
- Send us a letter to:
  Horizon Medical Appeals
  PO BOX 10194
  Newark, NJ 07101
Let us know:
1. Your name and Horizon NJ Health ID number
2. Your doctor’s name
3. That you want to appeal our decision
4. The reason you want to appeal
5. If the services are for urgent or emergency treatment

Horizon NJ Health must get back to you with a decision within 30 calendar days. If your appeal is about services for urgent or emergency treatment, we will tell you the results of your appeal within 72 hours (three days – weekends and holidays count).

If we do not approve the services you are asking for in your appeal, Horizon NJ Health will send you a letter and explain why. We will also tell you how to file an Internal Appeal. If you wish to appeal certain benefits, the medical necessity of the service may not be the issue, and the Independent Utilization Review Organization (Iouro) External Appeal process may not apply. These benefits may include:
- Adult Family Care
- Assisted Living Program
- Assisted Living Services (when the denial is not based on medical necessity)
- Caregiver/participant training
- Chore Services
- Community Transition Services
- Home-Based Supportive Care
- Home Delivered Meals
- PCA (including Personal Preference Program)
- Respite (daily and hourly)
- Social Day Care
- Structured Day Program (when the denial is not based on medical necessity)
- Supported Day Services (when the denial is not based on the diagnosis of TBI)

In these cases, please use the Fair Hearing process explained on page 51. Please note that these types of appeals cannot be pursued through an IURO External Appeal.

Dental Internal Appeals
If you disagree with Horizon NJ Health’s decision, you (or your provider, with your written consent) have a right to appeal this action. You have a right to appeal through Scion Dental’s Internal Appeal process. You also have the option to appeal to the Independent Utilization Review Organization (IURO) and a right to request a Fair Hearing. You must follow the following Internal Appeal Process.

Internal Appeal Process:
You can file an Internal Appeal by:
1. Calling Scion Dental at 1-855-878-5371 (TTY 1-800-508-6975); AND
2. Writing to Scion Dental at PO Box 295
   Milwaukee, WI 53201
If you call first, you must follow up your phone request by writing to Scion Dental at the address in #2 above.

In your letter, you should include an explanation for the reason you are appealing our decision and then sign your request for an appeal. You have 60 calendar days from the date on which the notification was sent to request an Internal Appeal.

However, if you are now receiving these services, and you want these services to continue automatically during the appeal, you must either request an Internal Appeal on or before the final day of the previously approved authorization, or request an Internal Appeal within 10 calendar days from the date on which the notification was sent, whichever is later.

If you do not request your appeal within these timeframes, the services will not continue during the appeal. Scion Dental will decide your Internal Appeal within 30 calendar days of receipt of your appeal.

If you or your treating provider believe this 30 calendar-day timeframe for deciding your appeal is too long and could harm your health, please call Scion Dental at 1-855-878-5371 (TTY 1-800-508-6975) and ask for an expedited or fast appeal. An expedited or fast appeal means that Horizon NJ Health will decide your Internal Appeal within 72 hours of receipt. You may ask for an expedited or fast appeal if you are an inpatient in a facility, if the care you received was for an urgent or emergency health concern or if it is medically necessary and taking 30 calendar days to decide the appeal could seriously harm you in some way.

If you call to request an expedited or fast appeal, you do not have to follow up your phone call with a written request.

External Appeal
If you want to appeal the denial of your Internal Appeal, you may ask that someone outside of Horizon NJ Health review your request for service. This is done by an IURO – a program administered by the Department of Banking and Insurance (DOBI) to review adverse UM determinations made by a health insurance carrier with respect to any health benefits plan for which the carrier uses UM features, whether potential, existing, or already happened. Within 60 days of the date of Horizon NJ Health’s Internal Appeal decision letter, you or your doctor must:

Fill out the form called Application for the Independent Health Care Appeals Program, sent to you with the results of your Internal Appeal decision from Horizon NJ Health. Be sure to sign the form. Your signature allows the IURO to review your medical records and other medical information that may be needed for your appeal.

The IURO will give you its decision within 45 days after it gets all the materials it needs to make a decision. You may present your information about your case directly to the Appeals Committee either in person or by telephone. You may have someone come with you to the proceedings.
If your appeal is about services for urgent or emergency treatment, you should call DOBI at 1-609-292-5316 x50998, or call toll free at 1-888-393-1062 (TTY 711) and ask that your appeal be reviewed within 48 hours (two days – weekends and holidays count). You still must complete the form. Horizon NJ Health must accept the decision of the Iouro.

**Fair Hearing**

In addition to your right to Horizon NJ Health’s appeal process, you have the right to ask the State to review Horizon NJ Health’s decision about your service following the completion of the Internal Appeal process. This is known as a Fair Hearing.

If you want to ask for a Fair Hearing, you must do so as soon as you can, but no later than 120 calendar days from the date of the notice of adverse decision following the Internal Appeal. You must send a letter to the State at:

**New Jersey Department of Human Services**  
**Division of Medical Assistance and Health Services**  
**Fair Hearing Section**  
**PO Box 712**  
**Trenton, NJ 08625-0712**

Let the State know in your letter:

1. **Your name and Horizon NJ Health ID number**
2. **Your doctor’s name**
3. **That you want a Fair Hearing**
4. **The reason you want a Fair Hearing**
5. **If the services are for urgent or emergency treatment**
6. **Your telephone number**
7. **Include a copy of the Horizon NJ Health denial letter**

If you qualify for and want to continue getting the benefits in question during the Fair Hearing, you must request this in writing 10 calendar days from the date of the Internal Appeal denial notice, or until the end of the prior approved authorization, whichever is later, even though you have 120 calendar days to request a Fair Hearing. If you do not submit a request for continuation of benefits within the required 10 calendar day time period, you may lose your right to the continuation of your benefits while you wait for the final results of the Fair Hearing. If you request continued benefits and your appeal is denied, you may have to pay the cost of the services.

Members must complete the Internal Appeal process prior to requesting a Fair Hearing. This request must be made in writing. At the hearing, someone outside of Horizon NJ Health and the State will review your request for services. This person is a judge from the Office of Administrative Law (OAL), who will listen to you and others who speak for or with you at the hearing. You have the right to be at the Fair Hearing or have a lawyer, friend or other person go with or for you. The OAL judge will give the State an opinion on your request and the State will then decide whether to accept or deny your request. The State will give you its decision within 90 days, unless your request is for urgent or emergency treatment.

If you want to appeal the State’s decision, you have the right to appeal to the Appellate Division of Superior Court.

**Grievance and Appeal Procedures (continued)**

Horizon NJ Health is responsible for holding Interdisciplinary Team (IDT) meetings when your care plan changes, or you ask for a change to your care plan, and one of the following applies:

- There is a health or safety risk
- Prior to the denial or reduction of services, or setting placement, due to costs exceeding or expecting to exceed the annual cost threshold
- There is a change in your level of care need
- A significant change in service hours or costs has occurred since your last IDT

In cases where one of the situations listed above applies, your MLTSS Care Manager will schedule the IDT meeting, which occurs as a telephone/conference call, to discuss your care. Your Care Manager will explain the IDT process and what to expect. Your Care Manager will explain who will be participating, what will be discussed regarding your care needs and annual cost cap threshold, and will also ensure you are aware of your grievance and appeal rights.

The IDT includes your Care Manager, the Care Manager’s supervisor, a Horizon NJ Health medical director, a MLTSS member advocate, a representative of the Division of Aging Services Office of Community Choice Options (OCCO), you and/or your family member or an authorized personal representative, and the Horizon NJ Health behavioral health administrator (if behavioral health services are received). You have the right to ask for an IDT meeting if you think you need one and you can invite any individual to participate in your IDT, including your PCP. Most often, your Care Manager, and possibly the member advocate, will be with you in your home for the IDT meeting, but all other participants will be on the telephone.

**During the IDT meeting, the cost effectiveness limitations of the program will be discussed, as well as the different options available in terms of services and settings, such as Nursing Facility settings and services provided in home and community-based settings. During the meeting you will be told of the decision verbally. If at any time during the IDT you or your representatives have questions, you are encouraged to ask them.**

At the end of the IDT meeting, if you are not satisfied with the outcome, you have the right to request a Fair Hearing. The MLTSS Department will send you a letter with the IDT outcome. The IDT outcome letter will include your Fair Hearing rights and application form.
Getting help in another language
Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-444-4410 (TTY 711). This document is also available in other languages, as well as other formats, such as large print and Braille.

Llame al 1-844-444-4410 (TTY 711).

Attention: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

ADVARSEL: Hvis du snakker en annen språk enn engelsk, kan du ta kontakt med språkguidestyringsfirma. Kall 1-844-444-4410 (TTY 711). Denne dokumentet er også tilgjengelig i andre språk, samt andre former, som store print og Braille.

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 1-844-444-4410（TTY 711）。

NOTIZ: Sind Sie nicht auf Deutsch, ist Ihnen ein kostenloser Sprachassistenten nach dem Atem 1-844-444-4410 (TTY 711) verfügbar. Sie finden diese Anleitungen und Service auch in anderen Sprachen.

Attention: Si parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-844-444-4410 (ATS 711).

Attention: Si parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-844-444-4410 (ATS 711).

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 1-844-444-4410 (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
1-800-537-7697 or 1-800-368-1019 (TDD)

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

Para ayudar en español, llame a 1-844-444-4410 (TTY 711).