



**Managed Long Term Services & Supports (MLTSS)
Member Handbook**

Welcome

Thank you for becoming a Horizon NJ Health member. You deserve quality health care coverage you can count on. The Managed Long Term Services & Supports (MLTSS) program is designed for people who have NJ FamilyCare and need health and long-term care services to stay in their homes and communities as long as possible. You also get the 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.

Please look through this MLTSS Member Handbook and keep it handy in case you need it later on. This handbook will help you understand the benefits Horizon NJ Health covers for those enrolled in the MLTSS program.

If you have questions, you can call Member Services toll free at **1-844-444-4410** (TTY **711**). We're here to help you 24 hours a day, seven days a week.

You may also write to:

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

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Words to Know

Key words are highlighted throughout this handbook. Look for these boxes for definitions that will help you understand your Horizon NJ Health benefits and services.

Important Phone Numbers

Member Services	We're here to help you 24 hours a day, seven days a week: 1-844-444-4410 .
TTY Services	Members with hearing or speech difficulties can call 711 .
Dental Services	Call Member Services at 1-844-444-4410 (TTY 711).
24/7 Nurse Line	If you have questions about your health, preventive screenings, medicine or test results, or just need peace of mind, you'll get reliable, expert advice you can count on: 1-800-711-5952 .
Choice Counseling Services	For help understanding the information in printed materials, call NJ FamilyCare at 1-800-701-0710 (TTY 1-800-701-0720).
Printed Member Materials	If you need materials, like a Provider Directory, call 1-844-444-4410 (TTY 711). There is no charge for printed materials, and your request will be processed within five (5) business days.

Top 10 Questions Asked by New Members

1. How do I know if a doctor or dentist is a Horizon NJ Health provider?

Answer: You can search for participating providers, dentists, hospitals and specialists by using our *Online Doctor & Hospital Finder* at horizonNJhealth.com/findadoctor. You can also call Member Services at **1-844-444-4410** (TTY **711**) for help to find providers near you.

2. Can I go to a doctor or dentist who is not a part of Horizon NJ Health?

Answer: No. For your care to be covered under your Horizon NJ Health plan, you must use a provider who participates with Horizon NJ Health. Your Primary Care Provider (PCP) coordinates all of your health care needs.

You can choose which participating PCP you want to see. If you don't choose a PCP, one will be assigned to you.

If you get care from a provider who does not participate with Horizon NJ Health without our approval, you may be responsible for the cost.

3. Can I change my PCP?

Answer: Yes. Call Member Services at **1-844-444-4410** (TTY **711**), and we will help you choose a new PCP. You will get a new member ID card with the updated information. If you need to visit your PCP before you receive your new card, call Member Services and we will help you.

4. Do I need a referral to see a specialist?

Answer: No. You do not need a referral to see an in-network specialist. You must select a provider who participates in Horizon NJ Health's network. If you get care from a provider who does not participate with Horizon NJ Health without our approval, you may be responsible for the cost.

5. Do I have dental coverage?

Answer: Yes. Call Member Services at **1-844-444-4410** (TTY **711**) if you have questions about your dental benefits.

6. If I have an emergency and the nearest hospital is not a part of Horizon NJ Health, will I have to pay the bill?

Answer: No. In an emergency, always go to the nearest hospital for care. You do not need to get approval from Horizon NJ Health to go to the Emergency Room (ER).

7. What do I do if I get a bill from a doctor?

Answer: You should not get bills for services covered by your plan. If you do get a bill, call Member Services at **1-844-444-4410** (TTY **711**). We will give you instructions on what to do.

8. How do I keep my coverage?

Answer: NJ FamilyCare members must renew their eligibility every year. If you do not renew on time, you may lose your eligibility. If you do not know your renewal date, call your county caseworker or the NJ FamilyCare Health Benefits Coordinator at **1-800-701-0710** (TTY **1-800-701-0720**).

9. How do I reach my MLTSS Care Manager?

Answer: Your MLTSS Care Manager will give you their phone number. You can also call Member Services at **1-844-444-4410** (TTY **711**) to reach your Care Manager or the on-call Care Manager.

10. What is the phone number for NJ FamilyCare?

Answer: The toll-free number is **1-800-701-0710** (TTY **1-800-701-0720**).

Your MLTSS Member ID Card

Always carry it with you

Your Horizon NJ Health MLTSS member ID card is mailed to you before your coverage begins. 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 see your doctor, dentist or specialist, when you fill a prescription, when you have lab work done, and if you go to a hospital ER. You can use your card as long as you are a member.

Please keep your 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 your member ID card

- Your name
- 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 about your dental benefits
- Our toll-free Member Services phone number
- Information on what to do in an emergency

Lost or stolen ID cards

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 from the State of New Jersey, your Horizon NJ Health member ID card and cards for any 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 helps your providers know how to bill for that service, supply 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 15).




Words to Know

Benefit: Service given to a person that is paid for by the health plan

Your MLTSS Member ID Card (continued)

Dental benefit indication

Member name
Member ID number
Primary Care Provider
Primary Care Provider phone
Issue date
Effective date



Horizon

**NJ FamilyCare
Managed Long Term
Services & Supports
(MLTSS)**

NAME

MEMBER ID NO: YHZ

PCP

PHONE

ISSUE DATE

EFFECTIVE

BC/BS Plan Codes 280/780


horizonNJhealth.com

Dental Benefit

No Copayments

**Pharmacies Group: HORIZON, BIN 610606,
ProCtrl: HMC**

086-19-153



Horizon

Independent licensees of the Blue Cross and Blue Shield Association.

horizonNJhealth.com

MLTSS Member Services
(including dental and vision): **1-844-444-4410**

TTY: **711**

MLTSS Provider Services: **1-855-777-0123**

Dental Provider Services: **1-855-878-5368**

Prior Authorization: **1-800-682-9094**

- Always carry this ID card. You must use your selected Primary Care Provider (PCP) for medical care. Members with Medicare Advantage or other insurance must use that plan's PCP. Refer to the member handbook for specific copay information.
- EMERGENCIES** — If you are having an emergency, call "911." You do not need approval to go to the ER. If you get emergency care, you should follow up with your PCP within 24 hours or as soon as possible.

- Hospitals must call to verify eligibility and obtain precertification for inpatient and outpatient hospital services.
- Standard Claims: Horizon NJ Health Claims Processing Department
PO Box 24078 Newark, NJ 07101-0406
- Dental Claims: Horizon NJ Health,
PO Box 299, Milwaukee, WI 53201
- Outside of NJ, the member only has coverage for urgent and emergent care. Out of state, non-Horizon NJ Health providers: submit claims to local BCBS plan.

Member Services

Emergencies

Register and Sign in at horizonNJhealth.com

You can access your plan information quickly and easily at horizonNJhealth.com. Once you sign up, you can:

- **Request an ID card.** We will mail it to you.
- **View your covered benefits.** This includes your benefit level and what is covered under your plan. You do not have copays for MLTSS services, but you do have a cost share, or Patient Payment Liability, for Assisted Living and Nursing Facilities.
- **Complete a Health Needs Survey,** learn about your health risks and see how you can make changes to your lifestyle to improve your health.
- **Change your Primary Care Provider (PCP).**
- **Read personalized health news articles** based on the information you provide in your health survey.
- **Enroll in a Disease Management program** to get help with a chronic condition, like asthma or diabetes.
- **Enroll in the Mom's GEMS (Getting Early Maternity Services) program** to get information for a healthy pregnancy and baby, if you are pregnant.

To register, visit horizonNJhealth.com and click *Member Sign In*.

We encourage you to sign up as soon as possible. This self-service tool is a useful resource so you can quickly access your plan information.

How Your Benefits Work

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.

If you did not select a PCP on your enrollment form, we will select one for you based on where you live and your age. You can change your PCP at any time. To change your PCP, sign in at horizonNJhealth.com or call Member Services. An authorized person acting for you may help you find a doctor.

Provider Directory

Horizon NJ Health has a large network of doctors and health care professionals that provide quality health care services. We have a Provider Directory that shows you who participates in our network. All types of providers are listed, including doctors, hospitals, laboratory services, pharmacies, general dentists, dental specialists and more.

You can search for a provider near you at horizonNJhealth.com/findadoctor. The *Doctor & Hospital Finder* is updated daily and lets you search for a provider by location, specialty, name and other fields.

You can also find a list of dentists who treat children 6 years of age or younger in *The NJFC Directory of Dentists Treating Children Under the Age of 6*. This separate list of dentists is located at horizonNJhealth.com/kidsdentists. You can also call Member Services at **1-844-444-4410 (TTY 711)**.

If you want a printed Directory, with a listing of providers near you, call Member Services.

Information about your provider, including your PCP and specialist, is available at horizonNJhealth.com/findadoctor. You can find a provider by:

- Name, office location and phone number
- Specialty
- Professional qualifications
- Languages spoken

To find additional provider information, including medical school residency, visit:

- NJ Division of Consumer Affairs: njconsumeraffairs.gov
- American Board of Medical Specialties: abms.org



Words to Know

Provider: A person or location (such as your PCP, hospital or dentist) that gives medical or dental care.



What if I cannot reach my doctor or dentist right away?

There could be times – maybe at night or on weekends – when your doctor or dentist is not in the office. You should still call your doctor's or dentist's office. Your doctor or dentist has a plan in place to help you, even if the office is closed.

How Your Benefits Work (continued)

The role of your PCP

If you need medical care, call your doctor's office first – at any time, 24 hours a day, seven days a week. Your doctor will know how to help. Most non-emergency health care services must be planned through your PCP.

Your health services are covered 24 hours a day, seven days a week. Horizon NJ Health covers services by PCPs, specialists, dentists, dental 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 you get care quickly.

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. NJ FamilyCare covers some services that Original Medicare does not cover, including:
- 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

You may also be eligible for certain MLTSS services, such as:

- 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, unless you're in a Provider Lock-in Program. 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 horizonNJhealth.com.

You can change your dentist when you sign in at horizonNJhealth.com, or call Member Services at **1-844-444-4410** (TTY 711).

Sometimes, Horizon NJ Health can deny a request to change to a new doctor, including:

- 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



Words to Know

Care Manager: Your Care Manager will be your main contact in the MLTSS program. He or she will work with you, your PCP and with input from your caregiver, to develop a Plan of Care to get the MLTSS services you need.

How Your Benefits Work (continued)

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. A PCP may ask that a member be changed to another doctor if:

- They cannot resolve conflicts with the member
- A member does not follow health care instructions, which stops the doctor from safely or ethically proceeding with the member's health care services
- 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. Dental treatment usually involves services performed on the teeth or performed to fix or replace teeth, such as fillings, root canals, extractions (removing teeth), dentures and crowns (caps). Some treatments may require seeing a dental specialist, such as an oral surgeon or maxillofacial prosthodontist (replacement of facial structures lost to disease or trauma).

Medical treatment involves services not directly involving the teeth, such as treatment for broken jaws, removal of cysts and benign or malignant tumors in the mouth.

If you are unsure, you can also call Member Services for help at **1-844-444-4410** (TTY 711).

Q. What if I need to see a specialist?

A. There may be times when your PCP refers you to a participating specialist. 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, the specialist may be able to act as your PCP and specialty care provider. Your Care Manager can help you with this request.

Q. What if my condition requires care from a doctor who does not participate with Horizon NJ Health?

A. The Horizon NJ Health network has thousands of doctors, dentists, and medical, behavioral health and dental specialists throughout New Jersey. If we do not have a provider 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 you need it. Your doctor or dentist will need to contact Horizon NJ Health. **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 opinion for any medical, dental, behavioral health or surgical diagnosis. Talk to your PCP, behavioral health provider or dentist about a second opinion. He or she will make all of the arrangements, or you may call Member Services for help finding another provider.



Words to Know

Specialist: A doctor or dentist who focuses on a certain field of medicine, like a cardiologist, Ob/Gyn or orthodontist.

How Your Benefits Work (continued)

Q. How do I reach my Care Manager or get answers about my Plan of Care?

A. You can call Member Services 24 hours a day, seven days a week at **1-844-444-4410** (TTY **711**). Your Care Manager is available weekdays, from 8 a.m. to 5 p.m., Eastern Time (ET). After hours or on weekends, an on-call Care Manager can help you. You may also call and leave a message for your Care Manager. If you leave a message, 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. For questions about how to get covered services authorized, or if you're not sure whether a service is covered, we are here to help you 24 hours a day, seven days a week at **1-844-444-4410** (TTY **711**). Your Care Manager, with your help, will develop a Service Plan of Care (SPOC) and needed services are authorized based on the your SPOC.

Q. What if I have questions about MLTSS eligibility requirements?

A. Eligibility for MLTSS services is based on a number of things, including your financial status and how well you can perform Activities of Daily Living (ADLs) like bathing, dressing and toileting. We can help people who want to know if they could be eligible for these services and start the process to refer for an in-person assessment. You can call anytime at **1-844-444-4410** (TTY **711**).

The State of New Jersey, Division of Aging Services, Office of Community Choice Options (OCCO), makes all final clinical eligibility decisions. The County Welfare Agency (CWA) determines financial eligibility.

Make an appointment right away

You should see your PCP soon after you become a member. A baseline physical will let your doctor review your health and health history and can prevent future health problems. We will urge 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. If you need to see your PCP before you get your member ID card, call Member Services. We will help arrange for you to see your PCP.



Regular Checkups are Important

Regular medical and dental exams and tests can help find problems early, when your chances for treatment are better. The services and screenings you need depend on your age, health and family history, lifestyle choices (like what you eat, how active you are and whether you smoke) and other factors.

How Your Benefits Work (continued)

Now is a good time to schedule a dental exam. Children and adults should get a dental exam and have their teeth cleaned at least twice a year. It is also important to complete all recommended dental treatment. If you need assistance in locating a dentist for you or your child, call Member Services at **1-844-444-4410** (TTY 711).

Very important: Keep your appointments!

Showing up for every appointment is the only way your doctor and dentist can make sure that you and your family 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, at least 24 hours before the appointment. You should make every effort to be on time to your appointment.

When you are sick or injured and need care, call your doctor or dentist right away for an appointment.

Appointment availability

Emergency services:

Immediately

Urgent care (not life-threatening):

Within 24 hours of calling

Sick visits:

Within 72 hours

Routine care (checkups for illness, such as diabetes):

Within 28 days

Specialist care:

Within four weeks for routine care, or within 24 hours for emergencies

New member physicals:

Within 90 days of initial enrollment for children and DDD adults; Within 180 days of initial enrollment for adults

Routine physicals (for school, camp, work, etc.):

Within four weeks

Prenatal care:

Within three weeks after a positive pregnancy test (three days if high risk)

– First and second trimester:

Within seven days

– Third trimester: Within three days

Lab and radiology services:

Within three weeks for routine care and 48 hours for urgent care; your results will be available within 10 business days for routine care and 24 hours for urgent care

Dental care:

Within 30 days for routine care, three days for urgent care (not life-threatening) and 48 hours for emergencies

Behavioral health care:

Within 7 to 10 business days 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 office or facility.

Doctor office wait times:

When you arrive on time for your appointment, you should not have to wait longer than 45 minutes to see your doctor.



When you are sick, your doctor will see you on the same day, in most cases.

Emergencies

You should only go to a hospital ER when your situation is an emergency. An emergency medical or behavioral health condition is a severe illness or injury in which not getting immediate medical attention could put your health and with respect to a pregnant woman, the health of her unborn child, in serious danger. Emergencies involve serious injury to bodily functions, organs or parts or risk for potential injury (such as thoughts of hurting self or others).

If you are having an emergency, 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 doctor to go to the ER. For urgent needs, call your Care Manager. For 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 emergencies that you should go to the ER for or call **911**:

- Chest pain
- Broken bones
- Difficulty breathing, moving or speaking
- Poisoning
- Heavy bleeding
- Drug overdose
- Car accident
- You have thoughts of hurting yourself or others

If you are in labor during pregnancy, follow your Ob/Gyn's instructions on what to do. 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.

If it is an emergency, call your PCP if you can. Your doctor will know how to help. He or she can send you to the closest hospital and let the hospital know you are coming. If there is no time to call your doctor, call **911**. 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 are covered for emergencies 24 hours a day, seven days a week. This includes follow-up care in and out of the hospital.

You should contact your Care Manager for coordination of care after an ER 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 – office vs. ER

A dental emergency that may need to be treated in an ER may include an injury or serious infection in your mouth or the area around your mouth that could put your life or health in danger unless you get treatment quickly. Dental emergencies can include:

- Dental infection causing a large area of facial swelling
- Injuries to the mouth or jaw (including knocked out teeth)
- Heavy, uncontrolled oral or facial bleeding
- A broken or dislocated jaw

Emergencies (continued)

If you have a dental emergency, call your dentist first. If you are unable to reach your dentist, call Member Services at **1-844-444-4410** (TTY **711**). After normal business hours, you can call our 24/7 Nurse Hotline at **1-800-711-5952**, 24 hours a day, seven days a week. For life-threatening emergencies, go to the ER or call **911**.

At the ER

Once at the ER, hospital staff will perform an ER screening exam. This is a covered benefit for all Horizon NJ Health members to see if the condition is an emergency.

For behavioral health ER visits, mental health providers will determine a working diagnosis and plan of action for treatment. Depending on your evaluation, if appropriate, you may be admitted to the hospital for treatment, given medication, provided with crisis counseling and/or referred for treatment after leaving the hospital.

If a child is a suspected victim of physical/child abuse and/or neglect, he or she will be examined at the ER.

When foster home placement of a child occurs after business hours, the child will have a medical examination at the ER.

After you leave the ER

Within 24 hours of an ER visit, call your PCP. If you cannot call, ask a friend or family member to call. You should visit your PCP for follow-up care, not the ER, within seven days of your discharge from the hospital. Your PCP will coordinate your care after the emergency.

Urgent medical and dental care

If your situation is not an emergency, but it is medically necessary for you to get treatment quickly, call your doctor or dentist. This is known as urgent care. Your doctor or dentist can make arrangements for you to come into the office quickly for 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 be treated in a medical or dental office 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 around a tooth
- Teething discomfort or loose “baby teeth”
- Broken natural teeth or lost fillings or crowns
- Pain or discomfort following dental treatment
- Bleeding following tooth extraction

Out of town?

If you have an emergency while out of town, go to the nearest hospital and 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 for help finding 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 will be covered by non-participating providers.

Horizon NJ Health will not cover care received outside of the United States and its territories.

Your Benefits

As a Horizon NJ Health member, you get the benefits you are entitled to through the NJ FamilyCare program.

Members with MLTSS benefits do not have copays for covered services. MLTSS members do have a cost share, or Patient Payment Liability for Nursing Facilities and any Community Alternate Residential Settings (CARS).

Make sure you know how Horizon NJ Health works, especially when it comes to emergency care, seeing your doctor and when you need an authorization. If you get services that are not covered by Horizon NJ Health or authorized by your PCP, you may get billed for those services. Before care is given, your doctor should tell you if a service is not covered and if you will be billed.

If you are not sure whether a service is covered, call Member Services at **1-844-444-4410** (TTY **711**).

What Horizon NJ Health Covers

You have access to NJ FamilyCare benefits.

Service	Benefit
Abortions	Covered by FFS.* Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests
Acupuncture	Covered
Autism Services	Covered by Horizon NJ Health and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include Applied Behavioral Analysis (ABA) treatment, augmentative and alternative communication services and devices, Sensory Integration (SI) services, allied health services (physical therapy, occupational therapy and speech therapy), and Developmental Relationship based services including but not limited to DIR, DIR Floortime and the Greenspan approach therapy.
Blood & Blood Products	Covered Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.
Bone Mass Measurement	Covered Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.

*Fee-for-Service

Your Benefits (continued)

Service	Benefit
Cardiovascular Screenings	Covered For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.
Chiropractic Services	Covered Covers manipulation of the spine.
Colorectal Screening	Covered Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer. <ul style="list-style-type: none"> • <i>Barium Enema</i> – Covered When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months. • <i>Colonoscopy</i> – Covered Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy. • <i>Fecal Occult Blood Test</i> – Covered Covered once every 12 months. • <i>Flexible Sigmoidoscopy</i> – Covered Covered once every 48 months.

Your Benefits (continued)

Service	Benefit
Dental Services	<p>Covered</p> <p>Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services.</p> <p>Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity.</p> <p>Examples of covered services include (but are not limited to): oral evaluations (examinations); X-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures).</p> <p>Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs.</p> <p>Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity.</p> <p>Children should have their first dental exam when they are a year old, or when they get their first tooth, whichever comes first. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through the age of three (3) years old. If additional care is needed, members can find a complete list of dentists who treat children 6 years of age or younger in <i>The NJFC Directory of Dentists Treating Children Under the Age of 6</i>. This separate list of dentists is located at horizonNJhealth.com/kidsdentists.</p>
Diabetes Screenings	<p>Covered</p> <p>Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>
Diabetes Supplies	<p>Covered</p> <p>Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.</p>
Diabetes Testing and Monitoring	<p>Covered</p> <p>Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.</p>



Your Benefits (continued)

Service	Benefit
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.
Durable Medical Equipment (DME)	Covered
Emergency Care	Covered Covers emergency department and physician services.
EPSDT (Early and Periodic Screening, Diagnosis and Treatment)	Covered Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, dental, vision, and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations (including the full childhood immunization schedule), lead screening and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.
Family Planning Services and Supplies	Covered Horizon NJ Health shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. <i>Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).</i>
Federally Qualified Health Centers (FQHC)	Covered Includes outpatient and primary care services from community-based organizations.

Your Benefits (continued)

Service	Benefit
Hearing Services/ Audiology	<p>Covered</p> <p>Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration.</p> <p>Hearing aids, as well as associated accessories and supplies, are covered.</p>
Home Health Agency Services	<p>Covered</p> <p>Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.</p>
Hospice Care Services	<p>Covered</p> <p>Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling.</p> <ul style="list-style-type: none"> • Covered in the community as well as in institutional settings. • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for members under 21 years of age shall cover both palliative and curative care. <p>NOTE: Any care unrelated to the member's terminal condition is covered in the same manner as it would be under other circumstances.</p>
Immunizations	<p>Covered</p> <p>Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.</p>
Inpatient Hospital Care	<p>Covered</p> <p>Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.</p> <ul style="list-style-type: none"> • <i>Acute Care – Covered</i> Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance). • <i>Psychiatric – For coverage details, please refer to the Behavioral Health chart.</i>
Mammograms	<p>Covered</p> <p>Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.</p>



Your Benefits (continued)

Service	Benefit
Maternal and Child Health Services	<p>Covered</p> <p>Covers medical services for perinatal care, and related newborn care and hearing screenings, including midwifery care, CenteringPregnancy, immediate postpartum LARC (Long-Acting Reversible Contraception) and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services).</p> <p>Also covers childbirth education, doula care, lactation support.</p> <p>Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.</p>
Medical Day Care (Adult Day Health Services)	<p>Covered</p> <p>A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.</p>
Nurse Midwife Services	<p>Covered</p>
Nursing Facility Services	<p>Covered</p> <p>Members may have patient pay liability.</p> <ul style="list-style-type: none"> • <i>Long Term (Custodial Care)</i> – Covered. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability. • <i>Nursing Facility (Hospice)</i> – Covered. Hospice care can be covered in a Nursing Facility setting. *See Hospice Care Services. • <i>Nursing Facility (Skilled)</i> – Covered. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting. • <i>Nursing Facility (Special Care)</i> – Covered. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.
Organ Transplants	<p>Covered</p> <p>Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants).</p> <p>Includes donor and recipient costs.</p>
Outpatient Surgery	<p>Covered</p>
Outpatient Hospital/ Clinic Visits	<p>Covered</p>

Your Benefits (continued)

Service	Benefit
Outpatient Rehabilitation <i>(Occupational Therapy, Physical Therapy, Speech Language Pathology)</i>	Covers physical therapy, occupational therapy, speech pathology and cognitive rehabilitation therapy.
Pap Smears and Pelvic Exams	Covered Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.
Personal Care Assistance	Covered Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.
Podiatry	Covered Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. <i>Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.</i>
Prescription Drugs	Covered Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.
Physician Services – Primary and Specialty Care	Covered. Covers medically necessary services and certain preventive services in outpatient settings.
Private Duty Nursing	Covered Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).



Your Benefits (continued)

Service	Benefit
Prostate Cancer Screening	Covered Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
Prosthetics and Orthotics	Covered Coverage includes (but is not limited to) arm, leg, back and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids and dentures.
Renal Dialysis	Covered
Routine Annual Physical Exams	Covered
Smoking/ Vaping Cessation	Covered Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: <ul style="list-style-type: none"> • 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), weekdays, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at njquitline.org.
Transportation (Emergency) <i>(Ambulance, Mobile Intensive Care Unit)</i>	Covered Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.
Transportation (Non-Emergent) <i>(Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)</i>	Covered by FFS. Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by Horizon NJ Health, PCP, or providers. Modivcare transportation services are covered. All transportation including livery is available for all members.

Your Benefits (continued)

Service	Benefit
Urgent Medical Care	<p>Covered</p> <p>Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).</p>
Vision Care Services	<p>Covered</p> <p>Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices and intraocular lenses.</p> <p>Yearly exams for diabetic retinopathy are covered for member with diabetes.</p> <p>A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma.</p> <p>Certain additional diagnostic tests are covered for members with age-related macular degeneration.</p>
<ul style="list-style-type: none"> • <i>Corrective Lenses –</i> 	<p>Covered</p> <p>Covers 1 pair of lenses/frames or contact lenses every 24 months for members age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older.</p> <p>Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.</p>

Behavioral health benefits

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

Your Benefits (continued)

Service	Benefit
Mental Health	
Adult Mental Health Rehabilitation <i>(Supervised Group Homes and Apartments)</i>	Covered
Inpatient Psychiatric	Covered
Independent Practitioner Network or IPN <i>(Psychiatrist, Psychologist or APN)</i>	Covered
Outpatient Mental Health	Covered
Partial Care <i>(Mental Health)</i>	Covered
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered
Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES)	Covered by FFS.

Your Benefits (continued)

Service	Benefit
Substance Use Disorder	
Substance Use Disorder Treatment	The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of Substance Use Disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification <i>ASAM 2 - WM</i>	Covered
Care Management Services	Covered
Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital-based) <i>ASAM 4 - WM</i>	Covered
Long Term Residential (LTR) <i>ASAM 3.1</i>	Covered
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management <i>ASAM 3.7 - WM</i>	Covered
Office-Based Addiction Treatment (OBAT)	Covered Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.

Your Benefits (continued)

Service	Benefit
Substance Use Disorder	
Opioid Treatment Services	Covered
Peer Recovery Support Services	Covered Includes coverage for Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment. Coverage for Non-Methadone Medication Assisted Treatment includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.
Substance Use Disorder Intensive Outpatient (IOP) <i>ASAM 2.1</i>	Covered
Substance Use Disorder Outpatient (OP) <i>ASAM 1</i>	Covered
Substance Use Disorder Partial Care (PC) <i>ASAM 2.5</i>	Covered
Substance Use Disorder Short Term Residential (STR) <i>ASAM 3.7</i>	Covered

Your Benefits (continued)

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

Service	Description
Acute Partial Hospitalization (Mental Health)	Services that provide a non-residential psychiatric rehabilitation program for members with serious mental illness
Adult Family Care	Living in the home or apartment of a trained caregiver who provides support and services to the member
Adult Mental Health Rehabilitation (AMHR)	A supervised residential group home that provides mental health services
Assisted Living Services	A facility licensed by the Department of Health to provide apartment-style housing
Assisted Living Program	Assisted living service to tenants of certain publicly subsidized senior housing buildings
Behavioral Management - Traumatic Brain Injury (TBI) (Group and Individual)	Program provided in or out of the home designed to treat the member and caregivers when the member has a TBI diagnosis
Care Management	A set of member-centered, goal-oriented, logical steps to ensure the member gets the services he or she needs in a supportive, effective, timely manner
Caregiver/Participant Training	Training for caregivers
Chore Services	Services needed to maintain the home in a clean and safe environment; not every day housekeeping tasks
Cognitive Therapy (Group and Individual)	Services to help support loss in function
Community Residential Services	Services that help support and provide supervision for members with a TBI diagnosis
Community Transition Services	Services provided to help move from an institutional setting into his/her own home in the community

Your Benefits (continued)

Service	Description
Home-Based Supportive Care	Services that assist with household needs (e.g., meal preparation, laundry)
Home-Delivered Meals	Prepared meals brought to your home
Inpatient Psychiatric Hospital Care	Mental health care services that you get in a hospital that requires you to be admitted as an inpatient
Medication Dispensing Device	A device to help give medications and medication reminders
Non-Medical Transportation	Transportation to gain access to community services and activities
Nursing Facility Services (Custodial)	Facility care with 24-hour medical supervision and continuous nursing care
Occupational Therapy (Group and Individual)	Services to help prevent loss of function
Opioid Treatment Services	Medication for maintenance and/or detoxification in combination with substance use disorder counseling in a licensed treatment facility
Outpatient Mental Health Clinic/ Hospital Services	Mental health services provided in a community setting for members with a psychiatric diagnosis
Partial Care Services	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)
Personal Emergency Response Systems	A device that allows a member to call for help in an emergency
Physical Therapy (Group and Individual)	Services to help prevent loss of function
Private Duty Nursing (Adult)	Medically necessary nursing services

Your Benefits (continued)

Service	Description
Residential Modifications	Physical adaptations to a member's private primary residence necessary to ensure health and safety (e.g., wheelchair ramp)
Respite Care (Daily and Hourly)	A benefit to give caregivers a rest
Social Adult Day Care	Community-based group program that provides health, social and related support services in a protective setting
Special Care Nursing Facility (SCNF)	Facility with 24-hour medical supervision and continuous nursing care for individuals who need intensive services beyond those provided in a regular nursing facility
Speech, Language and Hearing Therapy (Group and Individual)	Services to help prevent loss of function
Structured Day Program	Structured day program to assist with the development, independence and community living skills of members
Supported Day Services	Activities directed at the development of productive activity patterns for members
Vehicle Modifications	Modifications to a member or family vehicle to allow greater independence

Your Benefits (continued)

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

The following services are not covered by Horizon NJ Health or the Medicaid Fee-for-Service program:

- 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 military duty.
- 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.

Your Benefits (continued)

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, and complete any course of treatment he or she recommends. Dental visits should start when a child turns 1 year old or when the first tooth can be seen. All NJ FamilyCare members have comprehensive dental benefits. Twice yearly dental checkups are a covered benefit. More frequent visits are covered for members with special health care needs. Some services require prior authorization (approval) with documentation of medical necessity.

Orthodontic services are allowed for children and are age restricted. They are only approved with sufficient documentation of a handicapping malocclusion or medical necessity. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity.

You do not need prior authorization for routine dental care, such as regular cleanings, fillings and X-rays. You can choose your dentist or dental specialist from the *Online Doctor & Hospital Finder*, which includes a list of participating general dentists and pediatric dentists for members ages 0-6 years old. For a list of dentists, please visit horizonNJhealth.com/findadoctor and select *Dentist* from the dropdown menu. You can also call Member Services at **1-844-444-4410** (TTY **711**).

Vision services

Members are covered for routine eye exams every one or two years based on their age and health. There may be times when you may need more exams during the year or need to see a vision specialist (ophthalmologist).

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

You will need to see an eye doctor who participates with Horizon NJ Health. To find an eye doctor near you, visit horizonNJhealth.com/findadoctor or call Member Services at **1-844-444-4410** (TTY **711**).

Laboratory services

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

You can use the *Online Doctor & Hospital Finder* 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. Visit Patient.labcorp.com to register. LabCorp will give your test results to your doctor before posting them to your online account.



Words to Know

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

Your Benefits (continued)

Prescription services

Horizon NJ Health covers many medicines at little or no cost to you. The approved prescription drugs make up our formulary. It's important that the medicines you take are safe and effective. That's why Horizon NJ Health has a committee made up of doctors and pharmacists who review and approve 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. A prior authorization is an approval that the doctor needs to get from us before we cover the cost.

Certain over-the-counter (OTC) products are covered with a written prescription from the prescriber. For members residing in a long-term care facility, OTC medications are generally provided by the institution, rather than Horizon NJ Health. Some medicines are not covered under your pharmacy benefit. This includes, but not limited to, fertility agents, weight loss drugs and erectile dysfunction medications.

Horizon NJ Health requires the use of generic medicine when available. If your doctor decides that you must take 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're waiting for a response, the pharmacy can give you a 72-hour supply of the medicine. Our Pharmacy department will work with your doctor to meet your prescription needs. If you have questions, call **1-800-682-9094 x91016 (TTY 711)**.

The Approved Drug List (formulary) is updated annually and as changes are made or new medicines 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 that we mail to all members. Covered drugs, including those that need prior authorization, are listed on our website at horizonNJhealth.com/covered_drugs. There is no copay for your prescription drugs.

Horizon NJ Health allows up to a 30-day supply for medicines. If you are currently in a long-term care facility, there is usually a maximum of a 14-day drug supply eligibility. A supply of greater than 14 days is allowed for certain types of medicine (for example, eye drops). If you live in a long-term care facility, the facility will use institutional sized drug products (for example, insulin) where available.

You can have prescriptions filled at any participating pharmacy. To find the pharmacies near you, visit horizonNJhealth.com or call Member Services.



Words to Know

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

Your Benefits (continued)

Our website has information on pharmaceutical management procedures, including the formulary, policies and limitations. Limitations include quantity, plan, supply/fill, step therapy (trying less expensive options before “stepping up” to medicines that cost more) and age. For a paper copy of the pharmaceutical management procedures, call the Pharmacy Department at **1-800-682-9094 x81016 (TTY 711)**.

If you take prescription drugs for a chronic condition like diabetes or asthma, it is important to take them as directed. Taking your medicine correctly is key in managing your health condition.

What you can do:

- **Talk to your doctor** – review all medicines you take (both prescription and OTC) and let your doctor know if you are experiencing any side effects, like dizziness.
- **Talk to your pharmacist** – make sure you understand the instructions for taking your medicines.
- **Take as directed** – take all your medicines exactly as the label says to make sure they work the right way to treat your condition.
- **Refill your prescriptions timely** – refill your prescription before you run out of medicine. Ask your pharmacy about automatic refills so your medicine is always refilled and ready for you.
- **Fill all of your prescriptions at the same pharmacy** – this allows your pharmacist to see all the medicine you take in case there are issues.

If you have any questions about your medicine, talk to your doctor or pharmacist.

Pharmacy Lock-In Program

Members who see different doctors may have many types of medicine prescribed. 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 lets the pharmacist learn about your health and be more able to help you with your medicine. Members who use many pharmacies or doctors may be reviewed each month to make sure that they are getting the right care. If it’s decided that using only one pharmacy will help you get better care, you may be “locked-in” to one pharmacy. Horizon NJ Health members must use in-network, contracted pharmacies in the State of New Jersey to fill their prescriptions. We will send letters to the member, pharmacy and doctor when a Pharmacy Lock-in program is needed. Members can appeal a Pharmacy Lock-In.

Medical transportation

We will provide emergency ground or air transportation for MLTSS members.

All non-emergency medical transportation services will be provided by Modivcare. If you need special services or transportation for your medical care, you can call Modivcare at **1-866-527-9933 (TTY 1-866-288-3133)**. You can also book your transportation online at modivcare.com. For livery service, such as car service to a medical appointment, you can call Modivcare 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 before your transportation need. After your medical appointment is over, if you haven’t scheduled a pickup time, you or someone at the doctor’s office can call the *Where’s My Ride* phone number at **1-866-527-9934 (TTY 711)** and request a pickup. The transportation provider will pick you up within 90 minutes.

Your Benefits (continued)

To report any problems with your transportation to Modivcare, call **1-866-333-1735**.

Remember – do not call an ambulance for routine transportation.

Behavioral health services

Horizon Behavioral Health provides your behavioral health benefits. You can see a mental health or Substance Use Disorder provider as needed. If you need medicine for mental health and/or Substance Use Disorder treatment, your mental health and/or Substance Use Disorder provider can prescribe the medicine for you.

Contact a behavioral health provider or tell your Care Manager if you are experiencing any of the below symptoms:

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

Utilization Management

We want to make sure you get the right care, in the right setting. To do this, we have a Utilization Management (UM) process. The UM process consists of medical necessity review before services are given. This ensures that you get quality service from doctors, hospitals, dentists and other providers, as soon as possible.

Our team helps with 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 make sure you get the continuous care you need. If you have questions, please call your Care Manager or Member Services at **1-844-444-4410 (TTY 711)**.



Words to Know

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

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, we can help you find the services you need. We can also help you find doctors and clinics near 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* program

The Horizon *Healthy Journey* program will remind you when it's time for your preventive health screenings or services. You may hear from us through live and automated calls, or we may send you reminders in the mail. We will work with your doctors to make sure they are aware of your recommended services.

Women's services

If you need women's health services or you are going to have a baby, make an appointment with an Ob/Gyn or a certified nurse midwife (CNM) in Horizon NJ Health's provider network.

It's important for women to visit an Ob/Gyn for regular care. Women age 21 through 65 years old should have a pap test every three years. Women between the ages of 30 and 65 should be tested every five years if getting a pap test combined with a human papillomavirus test. A pap test is the best way to find pre-cancerous cells that may cause cervical cancer. Routine cervical cancer screening is covered, at no cost to you.

Yearly mammograms are recommended for women age 40 and older, and are covered, at no cost to you. A mammogram can find breast cancer early – often one and a half to two years before a lump is big enough to be felt.



Words to Know

Pap test: A cervical cancer screening

Programs for You (continued)

Help for pregnant women: Mom's GEMS

If you think you are pregnant, call your Care Manager right away for an appointment. As a mother-to-be, you can join the Mom's GEMS Program. GEMS stands for "Getting Early Maternity Services." Mom's GEMS can help you get good prenatal care, childbirth education, breastfeeding education, doula services, nutrition advice and, after your baby is born, postpartum information.

Once you learn you are pregnant, you will need to let your Board of Social Services know so you can keep your NJ FamilyCare eligibility throughout your pregnancy.

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

You should visit your Ob/Gyn as scheduled after the birth of your baby for a postpartum visit.

If you are pregnant or have children, you are likely eligible for the WIC (Women, Infants and Children) program. 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.

Horizon NJ Health can also help you with lactation services, such as breastfeeding classes/counseling and getting a breast pump and supplies.

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 through age 21.

The EPSDT program helps keep immunizations and well-child visits on track. It also 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 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:

- Within 3 to 5 days post hospital discharge
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- And once a year through age 20



Words to Know

Prenatal care: Care for pregnant women

Postpartum: Care for a woman after she delivers a baby

Programs for You (continued)

During well-child visits, the doctor will check your child's vision, teeth, hearing, nutrition, growth and development, give vaccinations, treat any problems identified and refer your child to a specialist, if needed. These visits are also a good time to ask questions and talk about any problems or concerns you have. Horizon NJ Health covers all of these services for members up to the age of 21.

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

Immunizations are safe and effective. By getting your child immunized, you can protect your child from serious illnesses, such as:

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

Children should get these important immunizations before their second birthday.

Children should have their first dental exam when they are a year old, or when they get their first tooth, whichever comes first. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through age 3. If additional care is needed, members can find a complete list of dentists who treat children 6 years of age or younger in *The NJFC Directory of Dentists Treating Children Under the Age of 6*. This separate list of dentists is located at horizonNJhealth.com/kidsdentists.

Get your child tested for lead poisoning

Lead poisoning happens when too much lead gets into the body, like eating or breathing it, or it can enter through the skin. According to New Jersey state law, children must be tested for lead poisoning between 9 and 18 months old (preferably at 12 months) and again between 18 and 26 months (preferably at 24 months old). Any child 6 months or older and who has been exposed to a known or suspected lead source should have a lead test right away. If a child between the ages of 24 months and 6 years old has not received a screening blood test, the child must get tested immediately, regardless of whether the child is determined to be at a low or high risk.

Children age 6 and under who have high lead levels will be placed in a lead care management program. Lead Care Managers are nurses who work with you to help keep your child lead free. The lead program gives you information about keeping your home lead free and safe. You will get information on blood lead levels, and how to prevent lead poisoning, including housekeeping, hygiene and appropriate nutrition. It's so important that you follow your doctor's instructions when dealing with lead problems.

Your Care Manager will work with your child's PCP, the Department of Health, WIC and laboratories to make sure your child's high blood lead levels are lowered so your child can be healthy.

Programs for You (continued)

Get help quitting smoking or vaping

Being smoke-free is one of the best things you can do to improve your health. By quitting smoking or vaping, you can improve your lung function and circulation. You can also reduce your risk of heart disease, cancer and other health problems. It may help you add years to your life.

The thought of quitting may be overwhelming, or you may not know where to start. We're here to help. We cover counseling, prescription medicines and over-the-counter products like nicotine patches and gum to help you stop smoking or vaping. You can also get help from:

- **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**), weekdays, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at njquitline.org.
- **NJ Quitcenters:** Get professional face-to-face counseling in individual or group sessions. To find a center, call **1-866-657-8677** (TTY **711**).

Horizon Neighbors in Health: Education Works

You can earn a high school diploma through our **Horizon Neighbors in Health: Education Works** program, at no cost to you. The program will:

- **Connect you** with groups in your area to help you study.
- **Give you telephone coaching** throughout the process to help you stay on track.
- **Work with you one-on-one** to understand your situation and remove any barriers that are preventing you from getting your high school diploma, such as transportation to the testing center or childcare during the test.*
- **Pay** the pre-test and test fees.**

To learn more, call **1-609-537-2076** (TTY **711**), weekdays, 9 a.m. to 5 p.m., ET, or visit horizonNJhealth.com/EducationWorks.

* Services will be provided when needed.
Not all members will receive these services.

** Limited to three attempts.

LifeLine Program

Horizon NJ Health works with SafeLink Wireless to offer the LifeLine Program at no cost to you. You may be eligible to get:

- A free smartphone, 4.5 GB of data and 350 monthly minutes
- Unlimited text messages
- Free calls to Horizon NJ Health Member Services that won't count toward your minutes

If you already have your own phone, you may be able to use it for this program. For more information and to see if you're eligible, apply at SafeLink.com and enter the Promo Code *Horizon*, or call **1-877-631-2550** (TTY **711**).

Your Rights and Responsibilities

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. Get a current list of Horizon NJ Health in-network doctors who can treat you.
 3. Have a doctor make the decision to say whether your services as a member should be limited or not given at all.
 4. Have no “gag rules” in Horizon NJ Health. This means doctors are free to discuss all medical treatment options with you even if the services are not covered by Horizon NJ Health.
- 5. Know how Horizon NJ Health pays its doctors. This will help you know if there are financial reasons tied to making medical decisions.
- 6. Not have doctors give you a bill for extra money. Your health insurance pays an amount of money to the doctor. The doctor cannot charge you more than your plan allows, even if that amount is not what the doctor chooses to charge.
- 7. Be part of the discussion with your doctor in making decisions about your health care.
- 8. Information and open talk about your medical condition and ways of treating that condition.
- 9. Choose from different ways of treating your condition that are presented in a clear and understandable way, regardless of the cost or what your benefits cover.
- 10. Have your medical condition explained to a family member or guardian if you are not able to understand it, and have it written down in your medical records.
- 11. Refuse medical treatment with an understanding of the results if you choose to not have medical treatment.
- 12. Refuse care from a specific doctor.
- 13. Get care that supports a meaningful quality of life free of harmful procedures, including unnecessary physical restraints or isolation, excessive medicine, physical or mental abuse and neglect.

Your Rights and Responsibilities (continued)

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 help finding a specialist if you need one.
 2. Have a doctor visit for a second opinion or to get another point of view in certain cases.
 3. See a specialist who has experience treating your disability or health condition.
 4. 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 is no longer in the Horizon NJ Health network, 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. It includes instructions that say what actions should be taken for a person's health if they are no longer able to make decisions. Federal law requires doctors to ask about a member's advance directive.

You have the right to:

- Ask questions to 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.

Your Rights and Responsibilities (continued)

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 Human Services if you are not satisfied with Horizon NJ Health's decision about a grievance or appeal.
 4. Use the Medicaid Fair Hearing process if you are eligible.
- Following Horizon NJ Health's rules for medical care.
- Giving information that is needed to a doctor and Horizon NJ Health so care can be provided to you.
- Asking your doctor questions so you can understand your health problems and the care you're getting.
- Developing treatment goals with your doctor that you both agree on.
- Following your doctor's advice that was agreed on and considering the results if you do not.
- Keeping appointments and calling in advance if you need to cancel.
- 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 copays (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.

Your member responsibilities

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

- Treating doctors and all health care providers with respect and kindness.
- Talking openly and honestly with your PCP or specialist when telling them about your health.
- Getting regular care from a doctor to protect your health. This includes making appointments for routine checkups and shots.



Your Rights and Responsibilities (continued)

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 as head of their household

Your personal health information

Federal rules protect your personal health information (PHI). This is information about you and may describe your medical history, insurance information, tests and test results and other information that helps you get the right care.

Horizon NJ Health uses your PHI to:

- Pay provider claims
- Give you information about care management programs and services that fit your needs
- Share with a personal representative, like a family member, at your request
- Share with law enforcement when required by law
- Share with researchers when requested, following legal requirements

Horizon NJ Health has procedures in place so your PHI stays private. This includes using secure technological systems, offices and records management procedures and training staff.

In addition, you have the right to:

- Privacy of your medical information and records
- Request access to review and copy your PHI
- Request something be added to your PHI
- Request certain use of the PHI and that the sharing of some information be restricted
- Request to get confidential communications of your PHI if the sharing to others could harm you
- Get information on certain things that are shared about you

If you want to make requests about your legal rights or need information, call Horizon NJ Health at **1-844-444-4410** (TTY **711**). Ask to speak to the Health Insurance Portability and Accountability Act (HIPAA) privacy coordinator.

If you would like to file a grievance about how your PHI was used, you may do so following the Grievance process described on page 62.

Advance directives

It's a good idea to make an advance directive. An advance directive is a legal form that lets your family and doctors know how you want to be treated if you become too sick to tell them. It is sometimes called a living will.

There are three kinds of advance directives in New Jersey:

- A **proxy directive** means you can choose an adult to make health care decisions for you if your doctor says you cannot understand your diagnosis or care options.

Your Rights and Responsibilities (continued)

- An **instruction directive** states what care you do or don't want if you're unable to make your own choices.
- A **combined directive** names a person and gives instructions for care.

Now, while you are healthy, is the time to think about an advance directive. Your doctor can help you make one. Talk to him or her about your care options and what to include.

You can find more information from your County Welfare Agency. An easy-to-use advance directive form is available on the State of New Jersey's website at state.nj.us/health/advancedirective. Once you create an advance directive, share it with your doctor and your loved ones, and keep a copy in a safe place.

Reporting abuse, neglect or exploitation

You have the right to get care without exploitation, fraud and abuse. Professionals, including care providers, are required to report suspected abuse, neglect or exploitation of any:

- Child or adult who lives in a community setting
- Elderly adult living in a nursing home or other long-term care facility

If you believe you are being abused, neglected or exploited, report it right away to the appropriate source listed below:

Adult Protective Services

The New Jersey Adult Protective Services (APS) program has offices in each of the 21 counties. Reports can be made to the County APS offices or to The Public Awareness, Information, Assistance & Outreach Unit 24-Hour Toll-Free Hotline at **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) 24-Hour Toll-Free Hotline at **1-877-NJ ABUSE (1-877-652-2873)** (TTY **1-800-835-5510**).

Facility-Based Complaints and Investigation

The Office of the Ombudsman for the Institutionalized Elderly handles reports 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@ltco.nj.gov

Write: The Office of the Ombudsman
PO Box 852

Trenton, NJ 08625-0852

Fax: **1-609-943-3479**

The NJ Division of Health Facility Survey and Field Operations investigates complaints against health care facilities, nursing homes, assisted living residences, comprehensive personal care homes, adult medical day care, and other licensed acute and long-term care facilities.

24-Hour Toll-Free Hotline: **1-800-792-9770**

Online: File a complaint at

web.doh.state.nj.us/fc/search.aspx

Write: New Jersey Department
of Human Services

Division of Health Facility Survey
and Field Operations

PO Box 367 Trenton, NJ 08625-0367

More About Horizon NJ Health

To make sure you get the best possible care, we update our technology and clinical guidelines with feedback from experts and practicing doctors.

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, we host a community health advisory meeting. These meetings include our members, community health advocates and community leaders to talk about ways to improve member services, health education and ways that we reach out to members. To join us at this meeting, email our Marketing team at HNJHAnswers@horizonNJhealth.com.

Member satisfaction survey results

Each year, our members are asked if they are satisfied with their health plan and providers. This is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. Your answers help us improve our services. Results of the most recent survey are available at horizonNJhealth.com or can be sent 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 agreements to pay some doctors more bonuses based on things such as member satisfaction, quality of care, control of costs and use of services. This does not affect decisions that result in providing fewer services. Horizon NJ Health does not reward providers for denying coverage.

Medical decision-making

Utilization Management (UM) decisions are based on the member's health care needs and services and the NJ FamilyCare benefit. Horizon NJ Health does not pay or offer rewards to those who make UM decisions or 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 covered.

If you would like more information about how your doctor is paid or how decisions are made, call Member Services at **1-844-444-4410 (TTY 711)**.

How we protect your private information

We want you to know how we use and protect your private information, and the rights you have regarding your protected health information (PHI). To read our Notice of Privacy Practices, visit horizonNJhealth.com/privacy-policy.

When You Have Medicaid and Other Health Insurance

If you have coverage through another insurance plan, including Medicare, in addition to Horizon NJ Health, your doctor must use the other insurance plan for payment before he or she bills Horizon NJ Health for your care. It's important to show ALL of your insurance member ID cards when you go to the doctor, to make sure he or she bills the right plan.

When you use benefits covered by another insurance plan, you will need to follow the requirements of that plan. This includes using network doctors.

The Division of Medical Assistance and Health Services (DMAHS) has a publication with information for members enrolled in both Medicare and Medicaid, "When you Have Medicaid and Other Insurance." You can find this at state.nj.us/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf. If you would like a copy of the publication or have questions, call Member Services at **1-844-444-4410 (TTY 711)**.

When you have both Medicare and NJ FamilyCare/Medicaid

If the Service is:	Use This Type of Doctor:
An approved, Medicare covered benefit (for example: primary care, lab tests, specialists, outpatient hospital service, radiology)	Use a Medicare doctor (does not need to be in the Horizon NJ Health network).
Inpatient hospital care	Use a Medicare hospital. If possible, use a hospital also in the Horizon NJ Health network.
Emergency care received at a hospital emergency department	Go to the nearest hospital.
A medically necessary service not covered by Medicare but covered by Horizon NJ Health (for example: dental services, hearing aids, personal care assistant services)	Use a Horizon NJ Health network doctor.
Given by a provider who has opted out of Medicare for Medicare Part A and Part B members and is not in Horizon NJ Health's network	Use providers who participate in Medicare to avoid being responsible for medical bills.
Given to a Medicare Advantage Health Plan member by an unapproved, uncovered out-of-network provider	Use providers who are in the Medicare Advantage Health Plan's provider network, to avoid being responsible for medical bills.
A prescription drug covered under Medicare Part D	Use a Medicare participating pharmacy.
For nursing facility care, including short-term inpatient rehabilitation settings	For guidance, contact the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY 711) , Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) or Horizon NJ Health Member Services at 1-800-682-9090 (TTY 711) .

When You Have Medicaid and Other Health Insurance (continued)

When You Have Other Insurance and NJ FamilyCare/Medicaid	
If the Service is:	Use This Type of Doctor:
An approved, covered benefit from the other insurance, prescription drugs and inpatient hospital stays	Use a doctor from that insurance's network (does not need to be in the Horizon NJ Health network).
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)	Use a Horizon NJ Health network doctor.
Given by a provider that is not in your other health insurance provider network and is not in Horizon NJ Health's provider network and was not authorized by your other health insurance	Use providers who are in your other insurance's provider network to avoid being responsible for medical bills.
A prescription drug covered by your other health insurance	Use a pharmacy that participates with your other health insurance to receive your prescription drugs.
A prescription drug not covered by your other health insurance, but is covered by Horizon NJ Health	Use a pharmacy in Horizon NJ Health's network.
An inpatient stay in your other health insurance provider hospital	Use a hospital that is in your other health insurance provider network. If possible, use a hospital that is also in Horizon NJ Health's network.
Emergency care received at a hospital emergency department	Go to the nearest hospital.
For nursing facility care	Use a facility that is in both your other health insurance and Horizon NJ Health's provider networks.

Managed Long Term Services & Supports Program

Through the MLTSS program, you get services and support to help with activities of daily living such as bathing, dressing, eating and toileting, and supportive activities such as making meals, shopping, cleaning and laundry. Eligibility for these services depends on many things, including how well you 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.

You will be assigned a dedicated Care Manager. The Care Manager will work with you, your caregivers and your PCP to create a Plan of Care based on your care needs. Once your Plan of Care is completed, your Care Manager will arrange your service providers and follow up with you to make sure that the services continue to meet your care needs.

We understand 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 even stronger by offering some support to fill the gaps that cannot be met by family and friends. By offering flexible services options based on your needs, the MLTSS program makes 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 someone to remain in the community. In such situations, the Care Manager may recommend that the member transition to a nursing facility or community residential setting

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

Our Member Services staff are ready to help you get the most out of your plan benefits. You can call us anytime at **1-844-444-4410 (TTY 711)**. Your Care Manager will be available weekdays, from 8 a.m. to 5 p.m. If you need help outside of those hours, you can 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 give detailed information. We will return your call within one business day.

Translation services and alternate formats

We have staff members who can speak many languages. If you speak another language, we can connect you to someone who does. We can arrange for a translator to talk over the phone with you and your doctor so you can get the care you need. We can also coordinate a sign language interpreter to be with you at the doctor’s office. 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, call Member Services toll free at **1-844-444-4410 (TTY 711)**.

Horizon NJ Health member communications are available in other languages. If you need information printed in another language or alternate format for a hearing or vision impairment, call Member Services.

Managed Long Term Services & Supports Program (continued)

Who qualifies for MLTSS?

To qualify for Horizon NJ Health's 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:
 - Qualifying for SSI in the community, or
 - Qualifying for NJ FamilyCare only - Institutional Level, or
 - 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 MLTSS, contact your local County Welfare Agency (Board of Social Services) or your local County Area Agency on Aging (AAA) – Aging and Disability Resource Connection (ADRC). OCCO makes the final decisions about enrollment into the MLTSS program. Horizon NJ Health will perform the screening and MLTSS eligibility for existing Horizon NJ Health members.

Keeping your membership

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

You must be eligible for NJ FamilyCare. A Renewal Application should be sent in **EVERY** year. Call NJ FamilyCare at **1-800-701-0710** (TTY **1-800-701-0720**) to find out your renewal date or to ask for a renewal form.

What you need to know:

- If you don't renew your NJ FamilyCare eligibility, you might have to start over as a new applicant, and the approval process will take longer.
- The NJ FamilyCare eligibility renewal process for members who are Aged, Blind and Disabled is different and requires different updates. For a list of information that may be requested for eligibility renewal, visit: state.nj.us/humanservices/dmahs/clients/medicaid/abd/ABD_Checklist_NJFC-ABD-CL-0416.pdf.
- Keep your contact information updated. NJ FamilyCare can show you how to do this.

What you need to do:

- Open and respond to all mail from your County Welfare Agency (CWA) or your eligibility-determining agency.
- Contact your case worker at your CWA or call NJ FamilyCare at **1-800-701-0710** (TTY **1-800-701-0720**). If you need the information for your local CWA, please call the Managed Care hotline at **1-800-356-1561** (TTY **711**) or visit state.nj.us/humanservices/dfd/programs/njsnap/cbss/index.html.

Managed Long Term Services & Supports Program (continued)

MLTSS member rights and responsibilities

You deserve the best health care, and Horizon NJ Health will help you get the care you need. We will treat you with respect, and there are certain rights you can expect from us. There are also responsibilities that we expect from you.

You will get a copy of the following Member Rights and Responsibilities when you join Horizon NJ Health. You must sign and return this form, so we know you have read and understand these guidelines.

You have the right to:

1. Ask for and receive information on the 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 getting your chosen and approved services.
4. Get services no matter what race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status or disability you are.
5. Have access to all services that are best for your health and welfare.
6. Make your own decisions after you understand the risks and possible effects of the decisions made.
7. Make decisions about your own care needs.
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 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 resident rights and receive a copy in writing, when admitted to an institution or community residential setting.
13. Be told about 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 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 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 to your Care Manager, including but not limited to, medicine, circumstances, living arrangements, and informal and formal supports, in order to develop your Plan of Care.

Managed Long Term Services & Supports Program (continued)

2. Understand your health care needs and work with your Care Manager to develop or change your goals and services.
3. Work with your Care Manager to develop and/or revise your Plan of Care so your services can be authorized and delivered timely.
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, medicine, circumstances, living arrangements, informal and formal supports to the Care Manager.
8. Tell your Care Manager if any problems occur or you are not happy with the services you receive.
9. Pay your room and board in a Nursing Facility or Community Alternative Residential Setting (CARS) 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

Every MLTSS member has a dedicated Care Manager. Your Care Manager is a nurse or

a social worker who provides supports and services to help with your daily needs.

Your Care Manager will:

- Help coordinate your care: doctors' visits, prescription medicines, behavioral health services, applying for services and coordinating with all your health care providers
- Call to check on you and will be available for you to call when you need them
- Work with you to develop and review your Plan of Care

We ensure that our Care Managers work in a conflict-free environment. Care Managers cannot:

- Work directly with members who are blood relatives
- Work with members who are related by marriage
- Be a direct-paid caregiver to the member
- Be financially responsible for or allowed to make financial or health-related decisions on behalf of the member they are assigned to

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, or you need help after hours or on weekends, please call **1-844-444-4410 (TTY 711)** and the on-call Care Manager can help you right away. If that happens, your Care Manager will get information about your call to make sure you got the help you needed.

You have the right to change your Care Manager and may do so by calling Member Services at **1-844-444-4410 (TTY 711)**.

Your Plan of Care

Your Plan of Care is a personalized plan that outlines what services and supports you need to meet your individualized needs. The goal is to help you get and stay as healthy as possible, so you can keep your independence and stay in your community. Your Plan of Care shows that we have all worked together to decide how we will help you.

How is a Plan of Care developed?

Your Plan of Care is based on your health status and health care needs. You and your Care Manager, with input from your caregiver, providers and doctors, will work together to develop your Plan of Care. Your Plan of Care will be reviewed at least every 90 days if you live in a community setting or pediatric specialty care nursing facility (SCNF). It will be reviewed at least every 180 days if you live in a Nursing Facility, non-pediatric SCNF or a Community Alternative Residential Services (CARS) setting. Your Care Manager may review your Plan of Care more often or sooner if your condition or situation changes. Your Plan of Care is updated at least every year to ensure you get the services you need.

Getting the services in your Plan of Care

Once you agree to and sign your Plan of Care, services (except for residential and vehicle modification) will be provided within 45 calendar days of your enrollment. You must use in-network, contracted providers to get covered MLTSS services. Your Care Manager will work with you to make appointments for your services. He or she will also call you regularly and come to your home to assess your needs and services, and to review and update your Plan of Care.

You will be told about any changes to your Plan of Care and you must state if you agree or disagree with these 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 Medicaid Fair Hearing for the reduction or denial of services.

If you disagree with any of these statements or services in your Plan of Care, you need to tell your Care Manager. You must review and sign off on any changes to your Plan of Care.

Your Care Manager will explain 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.

Your Plan of Care (continued)

Participant Direction and Personal Preference Program

The Personal Preference Program (PPP) is designed to give you the most independence possible so you have more control over making decisions, planning and managing your care.

You are the employer and are able to hire your own paid caregivers. 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.

You are responsible for overseeing caregivers or service providers. Members who are capable of directing their own care and choose to do so, should use the PPP.

Members who participate in the Participant Direction of Home and Community-Based Services choose either to be the employer of record of their workers or to name a representative to be the employer of record on his/her behalf.

As the employer, 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. Reviewing worker performance and addressing any concerns
6. Setting the wage to be paid to each worker within the boundaries of the Plan of Care funds
7. Training workers to give personalized care based on your needs and preferences
8. Ensuring that workers deliver only those services authorized, and reviewing and approving hours worked

9. Reviewing and ensuring documentation for services provided
10. Developing a backup plan for when a scheduled worker is not available or does not show up, and using it when needed

You or your guardian may choose an Authorized Personal Representative (APR) to take over the participant direction responsibilities for you. An APR may be your legal guardian, family member or other adult who can accept responsibility for you and make your decisions. Your APR must follow your wishes and respect how you want to be cared for. An APR is not paid for their service and may not serve as your worker. The APR must:

1. Be at least 18 years old
2. Live in New Jersey
3. Be present in your life and available to support your needs
4. Be responsible for completing needed paperwork, hiring and supervising your workers, overseeing services, signing timesheets and invoices and following up with a Public Partnership Customer Service Agent or your financial consultant if needed.
5. Be present for all scheduled visits and calls with your financial consultant
6. Follow all payroll rules and requirements

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

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

Your Plan of Care (continued)

Health care appointments

Tell your Care Manager about your medical appointments and what happened during the appointments. Include information about any changes to your medicines or services. If you are unsure about what happened, tell your Care Manager. Your Care Manager will help you understand what happened and help you include any new information in your Plan of Care.

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:

- Received a service not covered by Horizon NJ Health
- Sought care from a non-participating doctor without an 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 (except in cases where only a copay is due) and must make payment arrangements with the doctor or provider.

If you get a bill for any covered medical service, call your Care Manager or Member Services. We 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.

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), health and social needs, and your Plan of Care. 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 Plan of Care 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 authorization. This is to make sure you get the right care at the right place when you need it.



If you get a bill do not ignore it. Call Member Services and we will help you.

Your Plan of Care (continued)

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 Plan of Care. 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 MLTSS services to remain in the program, as well as meet all other requirements listed in the Eligibility section, *Who Qualifies for MLTSS*, on page 48.

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.

How do I get these services?

To get any of the 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.



Words to Know

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

Your Plan of Care (continued)

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.

NJ Register Ready

The NJ Office of Emergency Management (OEM) 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. To register, visit <https://www13.state.nj.us/SpecialNeeds/signin.aspx>. Your Care Manager can assist you if you need help registering.

NJ 211

NJ 211 connects people in need with services that can help. If there is a community emergency, 211 links emergency management professionals with the public. For more information, visit nj211.org or call **2-1-1** (TTY **711**).

Federal Emergency Management Agency (FEMA)

FEMA works with local governments to prepare for and recover from disasters. This includes working with emergency responders during disasters and helping rebuild after. New Jersey is part of FEMA's Region II. For more information, visit fema.gov.

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 records 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.

Your Plan of Care (continued)

Fraud, waste and abuse

We are committed to the prevention, detection and reporting of health care fraud, waste and abuse.

What is fraud, waste and abuse?

Fraud happens when someone knowingly gives false information that lets another person get a benefit they are not entitled to. Waste and abuse are when services are overused and directly or indirectly cause unnecessary costs.

Examples of provider fraud, waste and abuse

- Billing for services or goods that were not given
- Billing for the same services more than once
- Billing without the right proof
- Unbundling services or goods that are supposed to be billed together
- Billing for more costly services or goods than those that were given (also called “upcoding”)
- Forging or altering bills or receipts

Examples of member fraud, waste and abuse

- Selling or loaning your member ID card or the information on it to someone else
- Purposely getting services or goods you don’t need
- Selling your prescriptions or prescription medicines illegally
- Lying about your income or other things to be eligible for your health plan

Reporting Suspected Fraud, Waste and Abuse

To report suspected fraud, waste or abuse, please call:

- Horizon NJ Health Special Investigations Fraud Hotline at **1-855-FRAUD20 (1-855-372-8320)** (TTY 711)
- New Jersey Medicaid Fraud Division of the Office of the State Comptroller’s Office (MFD) at **1-888-9FRAUD (1-888-937-2835)**

All calls and information are confidential. You do not need to give your name or personal information.

For provider-related matters, please provide:

- Name, address and phone number of provider
- NPI or Tax ID of the provider
- Dates of events
- Specific details about the suspected fraud or abuse

For member-related matters, please provide:

- The person’s name, date of birth, Social Security number, member ID
- The person’s address
- Specific details about the suspected fraud, waste, or abuse.

Estate recovery

The Division of Medical Assistance and Health Services (DMAHS) can 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.

Your Plan of Care (continued)

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 also given 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

To change your address or phone number, you must call Member Services at **1-844-444-4410** (TTY **711**) or your Care Manager. It's important that we have your correct information so we can contact you.

You also must contact your County Welfare Agency (CWA). You get important notices about your NJ FamilyCare coverage and annual renewal.

Ending your membership

You can be disenrolled from the MLTSS program if you:

- Are no longer enrolled with Horizon NJ Health
- No longer meet financial or clinical eligibility criteria for long-term level of care
- Will not allow the Department of Human Services staff or its designee complete the clinical eligibility assessment
- Relocate to an unapproved licensed residence/setting
- Move out of New Jersey
- Are incarcerated
- Were transferred/enrolled into another waiver program or the State's Program of All Inclusive Care for the Elderly (PACE)

- Refuse to pay your room and board and/or patient payment liability
- No longer need the services offered in the MLTSS program
- Have not received services and/or cannot be contacted or located at the last known address
- Refuse services that are outlined in your Plan of Care and you refuse to voluntarily leave the program
- 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 have to appeal the disenrollment. If you are not happy with a State agency determination that there is not good cause for disenrollment, you may request a Medicaid Fair Hearing.

You can choose to end your membership

You may end your membership for any reason during the first 90 days after the date of enrollment or notice of enrollment (whichever happened later), and then during the Open Enrollment Period, which happens every 12 months. The State's Open Enrollment Period occurs between **October 1** and **November 15** each year.

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

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

Your Plan of Care (continued)

If you choose to leave the MLTSS program on your own, your Care Manager will hold a face-to-face meeting with you to discuss your options for care. You will need to sign a Voluntary Withdrawal Form. 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 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 90 days, you will be re-enrolled in Horizon NJ Health. If you become eligible again after 90 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:

- You will need to sign your enrollment application for your new health plan so we can send your medical records to your new health plan.
- Once your enrollment ends, you will need to destroy your Horizon NJ Health ID card. It's very important that you protect your privacy by destroying the old cards so no one can steal your identity or 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 on your own, you can list your reasons for leaving in writing.
- Enrollment and disenrollment must be verified and approved by New Jersey DMAHS.
- 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 your dentist changes the treatment plan. This prior authorization will be honored for as long as it is active, or for six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization is needed.

MLTSS Member Advocate

In addition to your Care Manager, you have access to a Member Advocate. A Member Advocate is someone who works with you, your care team and state representatives to make sure any questions about your MLTSS benefits, services and decisions are answered, and that your needs and goals are being met.

To speak with a Member Advocate, call **1-844-444-4410 (TTY 711)**, weekdays, from 8:30 a.m. to 5 p.m., or ask your Care Manager for a Member Advocate to call you.

Residence options

We will help you get care in the setting that is the most cost-effective and best suits your needs. You may get services in different settings based on your desires, the cost of the services and the safest environment.

Your Plan of Care (continued)

If you 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. Your Care Manager will evaluate the cost effectiveness of the Plan of Care if you receive home and community-based services. The cost of your Plan of Care is limited and must not be more than the rate set by the state.

Patient Payment Liability

If you live in a nursing facility, you may have to pay Patient Payment Liability. The Patient Payment Liability for Cost of Care is the 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.

You 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 told by the provider about the amount they will need to pay. This amount is usually equal to 75 percent of the member's income.

If you live in an assisted living residence, you must pay room and board payments and may also have to pay Patient Payment Liability. These payments are paid directly to the facility every month. You must make these payments to remain in the MLTSS program.

Nursing facility to community transition

If you live in a nursing facility, and want to move into the community, your Care Manager will work with you to determine if it is safe and cost effective to do so. Your Care Manager will create a Plan of Care for the services you will need 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 decided 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 you need to set up 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:

- 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 your Plan of Care. Services must also be based on need. You must have no other way to get these services yourself or from any other sources, including community resources.

Your Plan of Care (continued)

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

I Choose Home NJ

I Choose Home NJ is part of the federal program, "Money Follows the Person (MFP)," which aims to move people out of nursing homes and developmental centers, and back into the community. New Jersey residents may be eligible if they:

- Have lived in a nursing home or developmental center for at least 60 days
- Are interested in moving back into the community
- Are eligible for Medicaid at least one day prior to leaving the facility

Eligible residents may be able to move to an independent community setting with supports and services. To learn more about *I Choose Home NJ*, visit ichoosehome.nj.gov, or talk to your Care Manager.

Grievance and Appeal Procedures

We have a grievance procedure to resolve disagreements between members, providers and/or our operation or any cause of member dissatisfaction. Issues about emergency care will be addressed immediately. Grievances about urgent care will be addressed within 48 hours. We will not discriminate against a member or attempt to disenroll a member for filing a grievance or appeal.

Grievance procedure

You can file a grievance by phone or in writing. A grievance can usually be resolved by talking to Member Services at **1-844-444-4410** (TTY **711**). You may send a written grievance to:

Grievances Department
1700 American Blvd.
Pennington, NJ 08534

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

Here's what will happen when we receive your call or letter:

1. A Member Services representative will talk to you about your grievance and try to resolve it. If you submit a grievance by mail, a Member Services representative will contact you by telephone within 24 hours of receiving the grievance to help find a resolution. The representative will document all the information that you discuss.
2. If you are not happy with the resolution, tell the Member Services representative and the grievance will be forwarded to our 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 receiving the grievance.

Grievance and Appeal Procedures (continued)

Utilization Management Appeal Process:

Service Denial/Limitation/Reduction/Termination based on Medical Necessity

You and your provider should receive a notification letter within two business days of Horizon NJ Health's decision to deny, reduce or terminate a service or benefit. If you disagree with the Horizon NJ Health's decision, you (or your provider, with your written permission) can challenge it by requesting an appeal. See the summary below for the timeframes to request an appeal.

Stages	Timeframe for Member/ Provider to Request Appeal	Timeframe for Member/ Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be reached
<p>Internal Appeal</p> <p>The Internal Appeal is the first level of appeal, administered by Horizon NJ Health.</p> <p>This level of appeal is a formal, internal review by health care professionals selected by Horizon NJ Health who have expertise appropriate to the case in question, and who were not involved in the original determination.</p>	60 calendar days from date on initial notification/ denial letter	<ul style="list-style-type: none"> On or before the last day of the current authorization; or Within ten calendar days of the date on the notification letter, whichever is later 	30 calendar days or less from health plan's receipt of the appeal request
<p>External/IURO Appeal</p> <p>The External/IURO appeal is an external appeal conducted by an Independent Utilization Review Organization (IURO).</p>	60 calendar days from date on Internal Appeal notification letter	<ul style="list-style-type: none"> On or before the last day of the current authorization; or Within ten calendar days of the date on the Internal Appeal notification letter, whichever is later 	45 calendar days or less from IURO's decision to review the case
<p>Medicaid Fair Hearing</p>	120 calendar days from date on Internal Appeal notification letter	<p>Whichever is the latest of the following:</p> <ul style="list-style-type: none"> On or before the last day of the current authorization; or Within ten calendar days of the date on the Internal Appeal notification letter, or Within ten calendar days of the date on the External/IURO appeal decision notification letter 	A final decision will be reached within 90 calendar days of the Fair Hearing request.

Grievance and Appeal Procedures (continued)

Initial adverse determination

If Horizon NJ Health decides to deny your initial request for a service, or to reduce or stop an ongoing service that you have been receiving for a while, this decision is also known as an *adverse determination*. We will tell you and your provider about this decision as soon as we can, often by phone. You will receive a written letter explaining our decision within two business days.

If you disagree with the plan's decision, you, or your provider (with your written permission) can challenge the decision by requesting an *appeal*. You or your provider can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can call Horizon NJ Health at **1-844-444-4410 (TTY 711)**, 24 hours a day, seven days a week. Written appeal requests should be mailed to the following address:

Horizon Medical Appeals
PO Box 10194
Newark, NJ 07101

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

Internal appeal

The first stage of the appeal process is a formal internal appeal to Horizon NJ Health (called an Internal Appeal). Your case will be reviewed by a doctor or another health care professional, selected by Horizon NJ Health who has expertise in the area of medical knowledge appropriate for your case. We will be careful to choose someone who was not involved in making the original decision about your care. We must make a decision about your appeal within 30 calendar days (or sooner, if your medical condition makes it necessary).

If your appeal is denied (not decided in your favor), you will receive a written letter from us explaining our decision. The letter will also include information about your right to an External Independent Utilization Review Organization (IURO) Appeal, and/or your right to a Medicaid State Fair Hearing, and how to request these types of further appeal. You will also find more details on those options later in this section of the handbook.

If you wish to appeal certain benefits, the medical necessity of the service may not be the issue, and the Independent Utilization Review Organization (IURO) 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 Medicaid Fair Hearing process explained on page 66. These types of appeals cannot go through an IURO External Appeal.

Grievance and Appeal Procedures (continued)

Expedited (fast) appeals

You have the option to request an expedited (fast) appeal if you feel that your health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about your appeal. Also, if your provider informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize your life or health, or your ability to fully recover from your current condition, we must make a decision about your appeal within 72 hours.

Dental internal appeals

Dental Internal Appeals follow the same timeframes as those in the UM Appeals Chart. You can file a Dental Internal Appeal by:

1. Calling SKYGEN USA Dental at **1-855-878-5371 (TTY 1-800-508-6975);**

AND

2. Writing to SKYGEN USA Dental at
PO Box 295, Milwaukee, WI 53201

If you call first, you must follow up your phone request by writing to SKYGEN USA 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.

However, if you are currently getting these services, and you want them 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. SKYGEN USA Dental will decide your Internal Appeal within 30 calendar days of receipt of your appeal.

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 (IURO) Appeal

If your Internal Appeal is not decided in your favor, you (or your provider acting on your behalf with your written consent) can request an External (IURO) Appeal by completing the **External Appeal Application** form. A copy of the *External Appeal Application* form will be sent to you with the letter that tells you about the outcome of your Internal Appeal. You or your provider must mail the completed form to the following address within **60 calendar days** of the date on your Internal Appeal outcome letter:

Maximus Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, New York 14534

Office: **1-888-866-6205**

You may also fax the completed form to **1-585-425-5296**, or send it by email to stateappealseast@maximus.com.

If a copy of the *External Appeal Application* is not included with your Internal Appeal outcome letter, please call Member Services at **1-844-444-4410 (TTY 711)** to request a copy.

External (IURO) Appeals are not conducted by Horizon NJ Health. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either Horizon NJ Health or the State of New Jersey. The IURO will assign your case to an independent physician, who will review your case and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical condition makes it necessary).

Grievance and Appeal Procedures (continued)

You can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or your provider should fax a completed copy of the *External Appeal Application* form to Maximus Federal at **1-585-425-5296**, and ask for an expedited appeal on the form in **Section V, Summary of Appeal**. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about your appeal within 48 hours.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance (DOBI) at **1-888-393-1062** or **1-609-777-9470**.

The External (IURO) Appeal is optional. You don't need to request an External (IURO) Appeal before you request a Medicaid State Fair Hearing. Once your Internal Appeal is finished, you have the following options for requesting an External (IURO) Appeal *and/or* a Medicaid State Fair Hearing:

- You can request an External (IURO) appeal, wait for the IURO's decision and **then** request a Medicaid State Fair Hearing, if the IURO did not decide in your favor.
- You can request an External (IURO) Appeal **and** a Medicaid State Fair Hearing **at the same time** (just keep in mind that you make these two requests to different government agencies).

You can request a Medicaid State Fair Hearing *without* requesting an External (IURO) Appeal.

Medicaid State Fair Hearing

You have the option to request a Medicaid State Fair Hearing after your Internal Appeal is finished (and Horizon N Health has made a decision). Medicaid State Fair Hearings are administered by staff from the New Jersey Office of Administrative Law. You have up to **120 calendar days** from the date on your **Internal Appeal outcome letter** to request a Medicaid State Fair Hearing. You can request a Medicaid State Fair Hearing by writing to the following address:

Fair Hearing Section
Division of Medical Assistance
and Health Services
PO Box 712
Trenton, NJ 08625-0712

If you make an expedited (fast) Medicaid State Fair Hearing request and you meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid Fair Hearing request.

Please note: The deadline for requesting a Medicaid State Fair Hearing is always 120 days from the date on the letter that explains the outcome of your *Internal Appeal*. This is true even if you request an External (IURO) Appeal in the meantime. The 120 day deadline to ask for a Medicaid State Fair Hearing always starts from the outcome of your *Internal Appeal*, **not** your External (IURO) Appeal.

Grievance and Appeal Procedures (continued)

Continuation of benefits

If you are asking for an appeal because the plan is stopping or reducing a service or a course of treatment that you have already been receiving, you can have your services/benefits continue during the appeal process. Horizon NJ Health will automatically continue to provide the service(s) while your appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (or your provider, acting on your behalf with your written consent) file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, **whichever is later**.

Your services will *not* continue automatically during a Medicaid State Fair Hearing. If you want your services to continue during a Medicaid State Fair Hearing, you must request that **in writing** when you request a Fair Hearing, and you must make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; **or** within
- **10 calendar days** of the date on the letter informing you of the outcome of your External (IURO) Appeal, if you requested one; **or**
- On or before the final day of the original authorization, **whichever is later**.

Please note: If you ask to have your services continue during a Medicaid State Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of your continued services.

If you have any questions about the appeal process, you can contact Member Services at **1-844-444-4410** (TTY 711).

Interdisciplinary Team (IDT) Meeting

We are responsible for holding Interdisciplinary Team (IDT) meetings when your Plan of Care changes, or you ask for a change to your Plan of Care, 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
- A significant change in service hours or costs has occurred since your last IDT

In cases where one of the above situations applies, your Care Manager will schedule the IDT meeting, which will be a telephone/conference call, to discuss your care. Your Care Manager will explain the IDT process and what to expect. Your Care Manager will also explain who will be participating, what will be discussed and 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 in some cases the Member Advocate, will be with you in your home for the IDT meeting. All other participants will be on the telephone.

The meeting will discuss the cost effectiveness limitations of the program and the options available in terms of services and settings, such as Nursing Facilities and services provided in home and community-based settings. During the meeting you will be told of the decision. If you or your representatives have questions during the meeting, you are encouraged to ask them.

At the end of the IDT meeting, if you are not happy with the outcome, you have the right to request a Medicaid Fair Hearing. We will send you a letter with the IDT outcome and your Medicaid Fair Hearing rights and application form.

Privacy Notice

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of **September 23, 2013**.

The last revision date is **May 24, 2020**.

When we use the term "Customer Information," we are referring to financial or health information that is "nonpublic," including any information from which a judgment could possibly be made about you. When we use the term "Protected Health Information" or "PHI," we are referring to individually identifiable oral, written and electronic information concerning the provision of, or payment for, health care to you. We refer to Customer Information and PHI collectively as "Private Information."

For purposes of this Notice, "Horizon" and the pronouns "we," "us" and "our" refer to all of the HMO and licensed insurer subsidiaries of Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, including the entities listed on the last page of this Notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

HIPAA generally does not preempt other state and federal laws that give individuals greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

When it comes to your Private Information, you have certain rights. To exercise any of these rights, call Member Services at the phone number on the back of your member ID card.

Collection and Protection

What Private Information we collect

In providing your health coverage, we collect Private Information from the following sources:

- Information we receive from you or your subscriber on applications, other forms or websites we sponsor.
- Information we obtain from your transactions with us, our affiliates or others, such as health care professionals.
- Information we receive from consumer reporting agencies or others, such as Medicare, state regulators and law enforcement agencies.

How we protect Private Information

Our employees are trained on the need to maintain your Private Information in the strictest confidence. They agree to be bound by that promise of confidentiality and are subject to disciplinary action if they violate that promise. We also maintain appropriate administrative, technical and physical safeguards to reasonably protect your Private Information.

Your Rights

When it comes to your Private Information, you have certain rights

To exercise any of these rights, call Member Services at the phone number on the back of your member ID card. You have the right to:

- **Get a copy of your health and claims records**
You can ask to see or get a copy of your health and claims records and other Private Information we have about you. We will provide a copy or a summary of your health and claims records, usually within

Privacy Notice (continued)

30 days of your request. We may charge a reasonable, cost-based fee.

- **Ask us to correct health and claims records**

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say “no” to your request, but we will tell you why in writing within 60 days and advise you of your right to file a statement of rebuttal.

- **Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not. A verbal request may be considered, but must be followed up in writing.

- **Ask us to limit what we use or share**

You can ask us not to use or share certain Private Information for treatment, payment or our operations.

We are not required to agree to your request and we may say “no” if it would affect your care.

- **Get a list of those with whom we have shared Private Information**

You can ask for a list (accounting) of the times we have shared your Private Information for six years prior to the date you ask, whom we shared it with and why. We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as disclosures to you or authorized by you). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Get a copy of this Notice**

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

- **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your Private Information. We will make sure the person has this authority and can act for you before we take any action.

- **File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by calling the Member Services phone number on the back of your member ID card. We will not retaliate against you for filing a complaint.

- o You can file a complaint with our Privacy Office by sending a letter to:

Horizon BCBSNJ
Attn: Privacy Office, PP-16F
Three Penn Plaza East
Newark, NJ 07105-2200

- o You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

200 Independence Avenue, S.W.
Washington, D.C. 20201

Or calling **1-877-696-6775**

Or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

Privacy Notice (continued)

Your Choices

For certain Private Information, you can tell us your choices about what we share

If you have a clear preference for how we share your Private Information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions..

- **In these cases, you have both the right and choice to tell us to:**
 - Share information with the subscriber, your family, close friends or others involved in payment for your care.
 - Share information in a disaster relief situation.

If you are not able to tell us your preference (for example, if you are unconscious), we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- **In these cases, we never share your Private Information unless you give us prior written permission:**
 - Marketing purposes
 - Sale of your Private Information
 - Psychotherapy notes

If you give us your authorization, you are permitted to revoke that authorization at any time in writing. We will honor your revocation once it is processed, except to the extent that we have taken action in reliance upon your original authorization or the authorization was obtained as a condition of obtaining coverage. If you are not able to tell us your preference

(for example, if you are unconscious), we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

How we typically use or share your Private Information

We typically use or share your Private Information in the following ways:

- **Help manage the health care treatment you receive**
We can use your Private Information and share it with professionals who are treating you.

Example: A doctor sends us Private Information about your diagnosis and treatment plan so we can arrange additional services.

- **Run our organization**
We can use and disclose your Private Information to run our organization and contact you when necessary. We use Private Information for case management and care coordination, utilization review, quality assessment and improvement, network provider credentialing, population-based research to improve health or reduce health care costs, and contacting providers and members with information about treatment alternatives.

We may also use your Private Information for other health care operations activities including compliance and auditing activities, evaluating provider performance, underwriting and other rate-setting activities, formulary development, information systems management, fraud and abuse detection (by ourselves or for

Privacy Notice (continued)

other plans or providers), facilitation of a sale, transfer, merger or consolidation of all or part of Horizon BCBSNJ and/or its affiliated companies with another entity (including due diligence related to the transaction), customer service and general business management, among others.

Example: We may use and disclose Private Information to remind you about the availability or value of preventive care or of a disease management program.

- **Administer your plan**

If you are a participant or beneficiary of a self-funded group health plan, we may use and disclose your Private Information as described in this Notice. However, our use or disclosure is dictated by an arrangement with your employer (or other sponsor of your benefits plan) or that plan itself.

That plan may use and disclose your Private Information differently than is described here. With respect to your individual rights, you should ask your plan administrator how to exercise those rights, along with any other questions you may have regarding your plan's privacy policies and practices. This Notice also applies to Horizon BCBSNJ's employee health benefit plan.

- **Treatment, payment and health care operations**

We may use and disclose your Private Information for another covered entity's treatment, payment and health care operations purposes. In addition, we are permitted to disclose Private Information to other covered entities so they can conduct certain aspects of their health care operations. We may also disclose

it for purposes of their fraud and abuse detection or compliance. We will only disclose Private Information to another covered entity for these purposes if that covered entity has or had a relationship with you.

- **Disclosures to individuals involved in care or payment**

Under certain circumstances, we may disclose certain Private Information to a person, such as the subscriber, a family member or a friend, who is involved in your care or payment for that care.

- **Additional reasons for disclosure**
We may also use or disclose Private Information to:

- o Certificate holder or subscriber of your coverage, if it is information regarding the status of an insurance transaction, as permitted by law.
- o Military authorities, if you are or were a member of the armed forces.
- o Plan sponsor employees designated by the plan administrator as assisting in plan administration.
- o Conduct marketing-type activities, either through ourselves or through other companies on our behalf, with a valid authorization.
- o Inform you of health-related products or services that are included in or add value to your plan of benefits.
- o Engage in face-to-face marketing communication.
- o Distribute promotional gifts of nominal value.

Privacy Notice (continued)

Other ways we use or share your Private Information

We are allowed or required to share your Private Information in other ways; usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your Private Information for these purposes:

- **Help with public health and safety issues**
We can share Private Information about you for certain situations such as:
 - Preventing diseases
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
- **Research**
We can use or share your Private Information for health research.
- **Comply with the law**
We will share Private Information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
We can share Private Information about you with entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

We can share Private Information with a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties, as authorized by law. We can share Private Information with a funeral director when an individual dies.

- **Address workers' compensation, law enforcement and other government requests**
We can use or share Private Information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security and presidential protective services
- **Respond to lawsuits and legal actions**
We can share Private Information about you in response to a court or administrative order, or in response to a subpoena.
- **For use by business associates**
We can share Private Information about you to our business associates (BAs) that perform functions on our behalf or provide us with services if the Private Information is necessary for such functions or services. Our BAs are legally and contractually required to protect the privacy of your information, and are only permitted to use and disclose such information as set forth in our contract and as permitted by federal law.

Privacy Notice (continued)

- **Other**

Please note that we will limit the disclosure of certain highly confidential information in accordance with laws governing the special nature of the information (e.g., HIV/AIDS, substance abuse, mental health, sexually transmitted diseases and genetic information). We are prohibited from using and disclosing your genetic information for underwriting purposes. Also, where a state permits minors of a certain age or status to seek treatment without parental consent, information that would normally be provided to our customers may be limited.

It may be necessary to use or disclose your Private Information as described in this Notice even after coverage has terminated. In addition, it may be infeasible to destroy your Private Information. Thus, we do not necessarily destroy it upon termination of your coverage. However, any Private Information we keep must be kept secure and private, and used only for permissible purposes. In cases involving Private Information of deceased persons, Horizon must comply with HIPAA with regard to protecting the Private Information for a period of 50 years following the death of the individual.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Our Responsibilities

- We are required by law to maintain the privacy and security of your Private Information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Private Information.

- We must follow the duties and privacy practices described in this Notice, and give you a copy of it.
- We will not use or share your Private Information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of this Notice

Horizon BCBSNJ and its affiliated companies reserve the right to change the terms of this Notice, and the changes will apply to all Private Information we have about you. Our policies may change as we periodically review and revise them. The new Notice will be available upon request, on our website, and we will send a copy to you if the changes are material.

This Notice is effective as of **September 23, 2013**.

The last revision date is **May 24, 2020**.

This Notice of Privacy Practices applies to the following organizations

The Horizon Blue Cross Blue Shield of New Jersey-affiliated companies, all of which are independent licensees of the Blue Cross and Blue Shield Association, are:

Horizon Healthcare Services, Inc. d/b/a/
Horizon Blue Cross Blue Shield of New Jersey

Horizon Healthcare of New Jersey, Inc. d/b/a/
Horizon NJ Health, Horizon Insurance Company

Horizon Healthcare Dental, Inc.

Horizon Casualty Services, Inc.¹

Privacy Notice (continued)

Healthier New Jersey Insurance Company d/b/a
Braven Health

¹This affiliate is not a covered entity subject to the federal privacy rules.

Health care providers in Horizon BCBSNJ's provider network may participate with Horizon BCBSNJ in an organized system of care, referred to as an "organized health care arrangement." Horizon BCBSNJ and these providers may exchange your Private Information as necessary to carry out treatment, payment and health care operations relating to the organized health care arrangement.

Spanish (Español): Para ayuda en español, llame al **1-855-477-AZUL (2985)**.

Chinese (中文): 如需中文協助, 請致電 **1-800-355-BLUE (2583)**.

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Privacy Office, Three Penn Plaza East, PP-16F
Newark, NJ 07105-2200.



1700 American Blvd.
Pennington, NJ 08534
1-844-444-4410 (TTY **711**)
horizonNJhealth.com

Nondiscrimination Policy

Read about Horizon NJ Health's [nondiscrimination policy](#).

Getting Help in Your Language

If you need help understanding this information, you have the right to [get help in your language](#) at no cost to you.

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