Horizon

Horizon Blue Cross Blue Shield of New Jersey

Horizon NJ Health

Managed Long Term Services & Supports (MLTSS)

MEMBER HANDBOOK

Welcome

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

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

So welcome and thank you for joining Horizon NJ Health.

Remember, if you have questions any time – day or night – call our Member Services department toll free at 1-844-444-4410. TTY: 1-844-889-7700.

You may also write to Horizon NJ Health at:

Horizon NJ Health
MLTSS Member Services
210 Silvia Street
West Trenton, NJ 08628

We are here to help you.

Important Phone Numbers

Member Services
Someone is available to help you 24 hours a day, seven days a week: 1-844-444-4410

TDD/TTY Services
For people with hearing or speech difficulties: 1-844-889-7700

What's Inside

Words to Know

There are many words in this handbook and the medical world that you may not know. Look for these boxes for definitions that will help you get the most from your Horizon NJ Health membership.

Your Horizon NJ Health ID Card

Always Have it Available

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

> **Benefit –** service given to a person that is paid for by the insurance plan

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

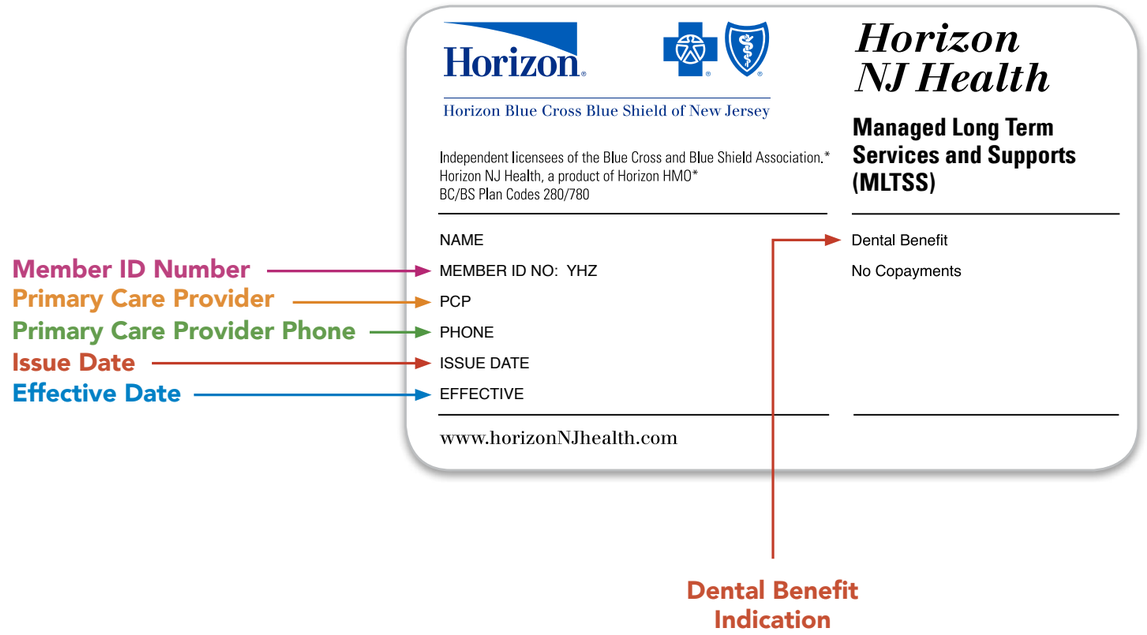
Please keep your Horizon NJ Health member ID card safe and never let anyone else use or borrow it. It is illegal to lend your member ID card or number to anyone. You could lose your NJ FamilyCare benefits and face prosecution.

What is on the Card

- Name of the member
- Effective date – the date your Horizon NJ Health benefits begin
- Your doctor's name and phone number
- A statement showing that you have dental benefits
- Our toll-free Member Services phone number is on the back of the card
- Information on what to do in an emergency is on the back of the card.

If it is Lost or Stolen

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



Other ID Cards

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

You will need to show your doctor the HBID card to get NJ FamilyCare Fee-for-Service services not covered by Horizon NJ Health (see the Your Benefits section on page 9).

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.

An authorized person acting for you may help you choose a doctor. If you did not select a PCP on your enrollment form, we selected one for you based on where you live and your age. Call Member Services if you would like to change your PCP. Member Services can also help you find a doctor in your area.

Provider – a person or location (such as a hospital) that gives medical care

Provider Directory

Horizon NJ Health has a list of providers that service members. This publication is called the Provider Directory. There are three different ways to view the directory:

1. Online at www.horizonNJhealth.com – updated daily, this Web-based directory lets you search for a provider by location, specialty, name and other fields. All types of providers are listed, including but not limited to doctors, hospitals, laboratory services, pharmacies and dental providers.
2. County-Specific Provider Directory – updated monthly, this directory is mailed to new members. It lists Primary Care Providers, dentists, hospitals, pharmacists and other providers in a member's county.
3. The Physician and Health Care Directory – updated a few times each year, this lists all specialists, hospitals, pharmacists and other providers. Your doctor uses this version when they need to send you to a specialist.

All versions of the Provider Directory include information such as the office hours, languages spoken and local public transportation services. To get a copy of a printed directory, call Member Services.

The Role of Your Primary Care Provider (PCP)

Call your doctor's office first – 24 hours a day, seven days a week – whenever you need medical care. Your doctor will know how to help. Most non-emergency health care services must be planned through your Horizon NJ Health PCP.

What if I cannot reach my doctor right away?
There could be times – maybe at night or on weekends – when your doctor is not in the office. You should still call your doctor's office. Your doctor has made arrangements to help you even if the office is closed

Your health services are covered 24 hours a day, seven days a week. Horizon NJ Health covers services by PCPs, specialists, certified nurse midwives, certified nurse practitioners, clinical nurse specialists, physician assistants and independent clinics in Horizon NJ Health's network. Your PCP may sometimes ask other health care providers help give timely care to you.

Specialist – a doctor who has been specially trained in a certain field of medicine

You may ask to have a Horizon NJ Health participating specialist as your PCP. You may also request a referral to certain care facilities for highly specialized care or to continue care with a non-participating doctor. These requests will be made through your Care Manager.

Questions and Answers About Your Doctor and Dentist

Q. If I have Medicare and Medicaid, do I need to see my Horizon NJ Health PCP?

A. For most health services, you can see your Medicare doctors as long as they accept patients who have Medicare.

There are health services that Medicare does not cover, but Medicaid does. These include:

- Dental services
- Vision services
- Hearing services
- Incontinence supplies
- Personal care assistant services
- Medical day care
- Personal Preference Program

For these services, you should only see a doctor in the Horizon NJ Health network.

Q. What if I want to change my doctor?

A. You can change your PCP at any time. Member Services can help you choose a new doctor and will send you a new Horizon NJ Health ID card with the new doctor's name and phone number.

Sometimes, Horizon NJ Health reserves the right to deny a request to change to a new doctor. Situations where Horizon NJ Health may deny a request include:

- If a PCP asks that a member not be included on his or her list of patients
- If a PCP has too many patients to take any more

Creating a positive, healthy relationship with your doctor is important. If your PCP believes that he or she cannot do this with a member, they may ask that the member be changed to another PCP. Other times in which a PCP may ask that a member be changed to another doctor include:

- If they cannot solve conflicts with the member
- If a member does not follow health care instructions, which stops the doctor from safely or ethically proceeding with the member's health care services
- If a member has taken legal action against the PCP

Q. How do I know if I should go to a doctor or dentist for care?

A. To help choose between going to your medical doctor or a dentist, use the following as a guide:

- Dental treatment usually involves services performed on the teeth or performed to fix or replace teeth, such as fillings, extractions, dentures and crowns (caps).
- Medical treatment most often involves services not directly involving the teeth, such as treatment for broken jaws or removal of cysts in the mouth.

Q. What if I need to see a specialist?

A. Your PCP will make the decision to send you to a participating specialist. You must have a referral to see a participating specialist. An eye doctor (for a medical problem such as cataracts or an eye infection) or a heart specialist are types of doctors you need a referral to see. Your PCP will give you a paper referral form or a prescription with the specialist's name and phone number.

You do not need a referral for:

- Routine gynecological care
- Family planning services
- Mammograms
- Routine obstetrical care
- Routine eye examinations by an optometrist or eye doctor
- Dental care
- Behavioral health care for DDD members
- Services at a Federally Qualified Health Center
- Emergency Room visits
- Medicare-covered services for members enrolled in Medicare

Referral – approval from a PCP to visit a specialist. The doctor will give you either a paper referral form or a prescription to take to the 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, you can ask your PCP for a "standing referral." A standing referral lets you to go to your specialist as often as the specialist needs to see you to treat your medical condition. The specialist may be able to act as your PCP and specialty care provider. Your care manager can help you with this request.

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

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

Q. What if I want a second opinion?

A. You can ask for another doctor's opinion for any medical or surgical diagnosis. Talk to your PCP. He or she will make all of the arrangements, or you may call Member Services for help finding another doctor.

Make an Appointment Right Away

Soon after becoming a member, you should see your PCP. A baseline physical specific to your age and sex will let your doctor measure your health, review your health history and help prevent future health problems. We will encourage your PCP's office to contact you to schedule the appointment if you do not schedule one. Your PCP's office should schedule appointments for routine visits within 28 days of your request.

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

Now would also be a good time to schedule a dental exam. Children and adults should have their teeth cleaned at least twice a year.

If you need to see your PCP before you get your ID card, call Member Services. A representative will help make arrangements for you to see your PCP.

Very important: Keep your appointments!

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

Showing up for every doctor's appointment is the only way your doctor and dentist can make sure that you are getting the quality care you deserve. Your doctor has saved time to see you. If you cannot keep an appointment, call and let your doctor or dentist know right away. That way, your doctor can use the time to help another patient.

Remember – if you or your child is sick, your doctor will see your child the same day in most cases

Appointment Availability

Emergency services: Immediately upon presentation at a service delivery site.

Urgent care: Within 24 hours of calling, your doctor will see you. Urgent care is when you need immediate medical attention but your concern is not life-threatening.

Symptomatic acute care: You will be seen within 72 hours. Having the flu is an example of this type of care.

Routine care: Checkups for illness, such as diabetes or high blood pressure, are available within 28 days.

Specialist care: Care can be received within four weeks, or within 24 hours if it is an emergency.

New member physicals: Appointments should be made within 90 days of initial enrollment for children and 180 days of initial enrollment for adults.

Routine physicals: Physicals needed for school, camp, work, etc. are scheduled within four weeks.

Prenatal care: If you have a positive pregnancy test, your first appointment will be scheduled within three weeks. Your appointment should be scheduled within your first trimester. If you are identified as having a "high-risk" pregnancy, your appointment will be within three days. During a woman's first and second trimester, appointments are available within seven days of the request. Appointments are available within three days during the last three months of pregnancy.

Lab and radiology services: Appointments are available within three weeks for routine care and 48 hours for urgent care. Your results will be available within 10 business days of receipt, or 24 hours for urgent care.

Dental care: Routine care is available within 30 days, urgent care within three days and emergency care within 48 hours.

Mental health care: Appointments are available within 10 days of referral for routine care and 24 hours for urgent care. If you have an emergency, you will be seen immediately when you get to your mental health provider.

When you get to the doctor's office on time for your appointment, you should not have to wait longer than 45 minutes.

Emergencies

Go or Do Not Go?

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

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

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

- Chest pain
- Broken bones
- Difficulty breathing, moving or speaking
- Poisoning
- Heavy bleeding
- Drug overdose
- Car accident
- Mental health emergency
- If you are in labor during pregnancy, follow your Ob/Gyn's instructions on what to do

If it is an emergency, call your Primary Care Provider (PCP) if you can. Your doctor will know how to help. He or she can send you to the closest participating 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.

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 provider if you have one

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

Dental Emergencies

A dental emergency is when injury to your mouth, or the area around your mouth, could put your life or health in danger unless you get fast treatment. Dental emergencies can include:

- Infection or swelling
- Pain from injuries to the mouth or jaw
- Heavy, uncontrolled bleeding
- A broken or dislocated jaw

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

At the Emergency Room

Once at the ER, hospital staff will perform an ER screening exam to find out if an emergency exists. This is a covered benefit for all Horizon NJ Health members to see if the condition can be reasonably considered an emergency. An emergency medical condition is a condition with certain serious symptoms (including severe pain) such that a layperson with an average knowledge of medicine and health could reasonably believe that not getting medical help could put the health of the person (and, with respect to a pregnant woman, the health of her unborn child) in serious danger; serious damage to bodily functions; or serious dysfunction of any body part. For a pregnant woman having contractions, an emergency exists when there is not enough time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

Urgent Care

If you are not sure if your illness or injury is an emergency, call your doctor or dentist first. Some examples of illness or injury that can wait until you talk to your doctor or dentist are:

- Cold, cough or sore throat
- Earaches
- Cramps
- Bruises, small cuts or minor burns
- Rashes or minor swelling
- Backaches from a pulled muscle
- Toothaches
- Swelling around a tooth

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

Out of Town?

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

If you need medical attention that is not an emergency, call your PCP right away to get help finding medical care from a doctor in the area. Horizon NJ Health will coordinate your care between your PCP and the out-of-network doctor.

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

Your Benefits

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

Make sure you know how Horizon NJ Health works, especially when it comes to emergency care, seeing your doctor and when you need a referral. Otherwise, you might be billed if you get services that are not covered by Horizon

What Horizon NJ Health Covers

You have access to NJ FamilyCare benefits

NJ FAMILYCARE BENEFIT	DESCRIPTION
Abortions and Related Services	Covered by Fee-for-Service for elective/induced abortions. Covered by Horizon NJ Health for spontaneous abortions/miscarriages
Acupuncture	Covered when provided by a licensed doctor
Adult Day Health	Covered
Audiology	Covered
Blood and Blood Plasma	Covered
Chiropractic Services	Coverage is limited to spinal manipulation
Cognitive Therapy	Covered
Dental	Preventive and diagnostic services (exams, cleaning and x-rays) are covered twice each year. Restorative services (fillings, root canals and crowns) are covered for teeth that need repair due to disease or injury Periodontic services (prevention, diagnosis and treatment of gum disease) are covered * Prior authorization needed for crowns, removable dentures, full and partial dentures, orthodontic, periodontics and oral surgery services
Diabetic Supplies and Equipment	Covered
Durable Medical Equipment & Assistive Technology Devices	Covered
Emergency Medical Care/ Emergency Services	Covered
EPSDT (Early and Periodic Screening, Diagnosis and Treatment)	Covered, including medical exams, dental, vision, hearing and lead screening services. Covered for treatment services identified through the exam
Family Planning	Covered. Covered by Fee-for-Service when services are not given by a Horizon NJ Health doctor. Coverage includes medical history and physical exams (including pelvic and breast), diagnostic & lab tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling

NJ Health or authorized by your Primary Care Provider (PCP). Before care is given, your doctor should tell you if a service is not covered and if you will be billed for the service.

If you are not sure whether a service is covered, call Member Services toll free at 1-844-444-4410, TTY: 1-844-889-7700.

Services Not Covered by NJ FamilyCare or Horizon NJ Health

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

What Horizon NJ Health Covers

NJ FAMILYCARE BENEFIT	DESCRIPTION
Hearing Aid Services	Covered
Home Health Agency Services	Covered, including nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment; physical, occupational and speech therapy services; pharmaceutical services; and durable medical equipment
Hospice Services	Covered in the community as well as in institutional settings. Room and board are included only when services are delivered in an institutional (non-private residence) setting. Hospice care for children under age 21 shall cover both palliative and curative care
Hospital Services (Inpatient)	Covered
Hospital Services (Outpatient)	Covered
Intermediate Care Facilities/ Intellectual Disability	Covered by Fee-for-Service
Laboratory Services	Covered, including routine testing related to the administration of atypical antipsychotic drugs
Maternity Services	Covered, including related newborn care and hearing screening
Medical Day Care	Covered
Medical Services Received at Group Homes and DYFS Residential Treatment Facilities	Covered
Medical Supplies	Covered

Dental Services

Good oral health is important to your body's overall health. You should visit your dentist at least twice a year for a checkup and cleaning. Even children as young as 1 year old should visit the dentist.

You do not need a referral from your PCP or prior authorization from Horizon NJ Health for routine dental care, such as cleanings and X-rays. If you need to make an appointment with a dental specialist, such as an oral surgeon, your dentist will give you a referral.

Vision Services

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

Ophthalmologist – a doctor who treats people with eye problems, treats eye diseases and does surgery

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

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

Laboratory Services

LabCorp is the laboratory services provider for Horizon NJ Health members. Your doctor will give you a prescription for laboratory testing.

Take that prescription and your Horizon NJ Health member ID card when you get lab work done.

You can use the Horizon NJ Health Provider Directory to find a LabCorp location near you. LabCorp also offers online appointment scheduling at all of its New Jersey Patient Service Centers. Visit www.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 Beacon: Patient, an online service, to download and print your test results on your own. Visit http://patient.labcorp.com to register. Note that LabCorp will give your test results to your doctor before posting them to your online account.

Prescription Services

Most prescription and non-prescription medicines are covered at no cost to you, as long as your doctor orders them and they are part of the approved Horizon NJ Health formulary. A committee of doctors and pharmacists reviews the list to make sure that the medicines are safe and effective.

Prescription – an order written by a doctor for a drug, test or other health service

Pharmacy services are covered for mental health/substance abuse medications (except methadone and its administration when prescribed for substance use treatment) when prescribed by mental health/substance abuse providers. Horizon NJ Health may require prior authorization from your provider if you need more than four prescriptions for mental health and/or substance abuse conditions each month. Drugs with weekly prescriptions will be counted as one per month.

What Horizon NJ Health Covers

NJ FAMILYCARE BENEFIT	DESCRIPTION
Mental Health Inpatient Hospital Services (Including Psychiatric Hospitals)	Covered
Mental Health Outpatient Services (Excluding Partial Care Services)	Covered
Mental Health – Home Health	Covered
Methadone (Maintenance and Administration)	Covered
Nurse Midwife	Covered
Nurse Practitioner	Covered
Optical Appliances	Covered for select eyeglasses and contact lenses as follows: • Age 18 and under and 60 and older – Replacement eyeglasses or contact lenses annually if prescription changes • Age 19 to 59 – Replacement eyeglasses or contact lenses every two years if prescription changes Replacement eyeglasses or contact lenses may be dispensed more frequently if significant vision changes occur. Contact lens exams and fittings are covered only when deemed medically necessary over glasses.

Horizon NJ Health requires the use of generic medicine when available. If your doctor decides that you must have a medicine that is not in the formulary, including a brand-name medicine exception, he or she can ask for special permission for you to get the medicine. While you are waiting for a response, the pharmacy can provide a 72-hour supply of the medicine. The Horizon NJ Health Pharmacy department will work with your doctor to fulfill your prescription needs. If you have questions, call toll free 1-844-444-4410 (TTY: 1-844-889-7700).

Formulary – a list of approved medicines that Horizon NJ Health covers

You can have prescriptions filled at any participating pharmacy. For a list of pharmacies or to find the pharmacy nearest to you, call Member Services. Participating pharmacies are also listed in the Provider Directory and on the Horizon NJ Health website at www.horizonNJhealth.com.

The website also has information on pharmaceutical management procedures, including the formulary listing, policies and limitations. Limitations include quantity limits, days' supply/fill limits, age limits, and gender restrictions. Paper copies of the pharmaceutical management procedures are available by contacting the Pharmacy department at 1-844-444-4410 (TTY: 1-844-889-7700).

Pharmacy Lock-In

Members who see many different doctors may have many types of medicine prescribed to them. This can be dangerous. The Pharmacy Lock-In program coordinates a member's care between pharmacies and doctors. To make sure your pharmacy care is coordinated, you should use only one pharmacy to fill your prescriptions. This will let the pharmacist learn about your health and be better able to help you with your medicine needs. Members who use many pharmacies or doctors may be reviewed each month to make sure that they are getting the proper care. If it is decided that using only one pharmacy will help the member get better care, the member may be "locked-in" to one pharmacy. We will send letters to the member, pharmacy and doctor when a lock-in is needed. If you wish to file a complaint about the lock-in decision, follow the complaint process on page 44.

Medical Transportation

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

The following services will be provided by the Fee-for-Service program, but may require medical orders from your provider: all non-emergency transportation, such as mobile assistance vehicles, and non-emergency basic life support ambulance (stretcher) for any NJ FamilyCare service. Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are covered.

If you are a homebound member and you need special services or transportation for your medical care, you may be able to get these services through LogistiCare, the Medicaid transportation vendor. Call them directly at 1-866-527-9933 (TTY: 1-866-288-3133) to set up transportation for a medical appointment. Call by noon at least two days in advance of your transportation need. A homebound member is someone whose condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing

What Horizon NJ Health Covers

NJ FAMILYCARE BENEFIT	DESCRIPTION
Optometrist Services	Covered for one routine eye exam per year
Organ Transplants	Covered for transplant-related medical costs for the donor and recipient, including donor and recipient inpatient hospital costs.
Orthodontic Services	Coverage is limited to members up to age 21 who require these services due to medical need, including developmental problems or jaw injury. Treatment must be completed by the member's 21st birthday.
Orthotics	Covered
Outpatient Diagnostic Testing	Covered
Partial Care Program	Covered
Partial Hospital Program	Covered
Pediatric Day Health	Covered
Personal Care Assistant	Covered
Podiatrist Services	Covered. Routine hygienic care of feet, including the treatment of corns and calluses, trimming of nails and other hygienic care in the absence of a pathological condition, is not covered.

special transportation, or getting help from another person), and doing so takes a lot of planning and effort. Homebound members are advised by their doctors not to leave home more than needed because of their medical condition(s).

Once your appointment is finished, you or someone at the doctor's office can call the "Where's My Ride" phone number at 1-866-527-9934 and request that transportation be sent to pick you up. The transportation provider will pick you up within 90 minutes.

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

Remember – do not call an ambulance for routine transportation.

Mental Health Services

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

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

Utilization Management

Horizon NJ Health wants to make sure you receive the most appropriate care for your problem, in the right setting. To do this, we have a Utilization Management (UM) process. This process ensures that you get timely, efficient and quality service from doctors, hospitals, dentists and other providers.

Ambulatory Surgical Center – a site that provides surgical care but does not provide overnight care

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

Most of all, we work with your PCP or specialist to ensure that you get the continuous care you need. Horizon NJ Health has special staff who can help you with UM questions. If you have questions about our UM process, please call Member Services at 1-844-444-4410, TTY: 1-844-889-7700.

Programs for You

Horizon NJ Health helps members manage many health issues. Talk to your care manager for information about these issues:

- Asthma
- Diabetes
- Congestive Heart Failure
- Hypertension
- COPD
- HIV/AIDS

What Horizon NJ Health Covers

NJ FAMILYCARE BENEFIT	DESCRIPTION
Prescription Drugs (Retail Pharmacy)	Covered, including atypical antipsychotics, Suboxone and Subutex or any other drug within this category when used for the treatment of opioid dependence, and drugs that may be excluded from Medicare Part D coverage. No coverage for erectile dysfunction drugs and drugs not covered by a third-party Medicare Part D formulary
Prescription Drugs (Doctor-Administered)	Covered by Medicare Part B
Primary Care, Specialty Care and Women's Health Services	Covered
Private Duty Nursing	Covered
Prosthetics	Covered
Radiology Services (Diagnostic & Therapeutic)	Covered
Rehabilitation Services (Outpatient Physical Therapy, Occupational Therapy and Speech Therapy)	Covered
Sex Abuse Examinations and Related Diagnostic Testing	Covered by Fee-for-Service
Social Necessity Days	Covered by Fee-for-Service; limited to no more than 12 inpatient hospital days

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.

Family Planning Services

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

Help for Pregnant Women: Mom's GEMS

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

Postpartum – care for a woman after she delivers a baby

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

- At least once during the first two months, or once you know you are pregnant
- Every four weeks during the first six months
- Every two weeks during the seventh and eighth month
- Every week during the last month
- Between 21 to 56 days after the birth of your baby

Prenatal Care – care for pregnant women

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

Keeping Children Healthy with CHAMPS

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

CHAMPS stands for "Children's Health Assessment and Maintenance of Preventive Services," and the program helps maintain the health of children from birth until they are 21 years old. CHAMPS helps keep immunizations and well-child visits on track and reminds parents to have their child's PCP screen for medical problems early and keep checking for problems as the child grows.

What Horizon NJ Health Covers

NJ FAMILYCARE BENEFIT	DESCRIPTION
Specialty Foods (Medical Foods)	Coverage is limited to nutritional supplements requiring medical supervision for members with inborn errors of metabolism and related genetic conditions. Medical foods and special diets for all other medical conditions are not covered
Substance Abuse (Inpatient and Outpatient)	Covered
Substance Abuse (Day Treatment/ Partial Hospitalization)	Covered
Substance Abuse (Outpatient and Intensive Outpatient)	Covered
Substance Abuse (Residential – Halfway House and Short-term Residential)	Covered
Sub-acute Medically Managed Detoxification and Enhanced Medically Managed Detoxification	Covered
Transportation Services – Emergency Ambulance (911)	Coverage is limited to ambulance for medical emergencies only
Transportation to Medically Necessary Services – Livery Transportation (Bus and Train Fare or Passes, Car Service, Mileage Reimbursement)	Covered by Fee-for-Service through LogistiCare. To schedule, call LogistiCare at 1-866-527-9933 (TTY: 1-866-288-3133).
Transportation to Medically Necessary Services - Non-emergency Ambulance, Mobile Intensive Care Units and Invalid Coach	Covered by Fee-for-Service through LogistiCare. To schedule, call LogistiCare at 1-866-527-9933 (TTY: 1-866-288-3133).

Taking children to the doctor is very important for their healthy growth and development. Children need to go to the doctor several times a year up to age 2 and at least once a year from the ages of 2 to 20. Call your child's PCP to schedule visits when your baby is at these ages:

- 2 to 6 weeks
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- And once a year between ages 2 and 20

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

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

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

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

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

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

Test Your Child for Lead Poisoning

According to New Jersey state law, children must be tested for lead poisoning, first between 9 and 18 months old (preferably at 12 months) and again by age 2. Children between the ages of 27 months and 6 years should be tested if not previously tested. Lead case management is given to all Horizon NJ Health members up to 6 years of age who have high blood lead levels. The lead program gives you information about keeping your home lead free and safe. You will get information on blood lead levels and preventive measures, including housekeeping, hygiene, appropriate nutrition and why it is so important that you follow your doctor's instructions when dealing with lead problems.

Your Horizon NJ Health care manager will work with your child's PCP, the Department of Health, WIC and laboratories to make sure that any high blood lead levels found in your child are lowered so your child stays healthy.

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

Your Rights and Responsibilities

As a Horizon NJ Health member you have the right to:

- 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 Primary Care Provider (PCP) or doctor who will help you. A PCP is the doctor you will see most of the time who will coordinate your care. He or she will be there for you, 24 hours a day, 365 days a year, if you need urgent care. This includes the right to:

1. Choose your own doctor from the Horizon NJ Health list of doctors.
2. Have a doctor make the decision to say whether your services as a member should be limited or not given at all.
3. Know how Horizon NJ Health pays its doctors. This will help you know if there are financial reasons tied to making medical decisions.
4. 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, even if that amount is not what the doctor chooses to charge.
5. 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.
6. Refuse medical treatment with an understanding of the results if you choose to not have medical treatment.
7. Refuse care from a specific doctor.
8. 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.

You have the right to:

- Have a choice of specialists. These are doctors who treat special illnesses or problems. This includes the right to:

1. Get information about what you have to do to see a specialist. This is called the referral process.
2. Have a second opinion or a visit to a doctor for another point of view in certain cases.

3. Be referred to a specialist who has experience treating your disability or health condition if you have a disability or condition that lasts a long time.

4. Request a referral that you can use over again when you need to see a specialist for a medical condition that is long-lasting.

5. Get care from a doctor who does not work with Horizon NJ Health when a Horizon NJ Health doctor is not available.

You have the right to:

- Call 911 for what may be a life-threatening situation without letting Horizon NJ Health know before you do it. If you go to the Emergency Room (ER), this includes the right to:

1. Have Horizon NJ Health pay for a medical screening exam in the ER to see whether an emergency medical condition exists.

You have the right to:

- Certain coverage benefits after the birth of a child. This includes the right to:

1. Stays in the hospital after you have had a baby that are no less than 48 hours for a normal vaginal delivery and no less than 96 hours after a cesarean section birth.

2. Get up to 120 days of continued coverage, if it is medically necessary, from a doctor who no longer works with Horizon NJ Health, including:

- Up to six months after surgery
- Six weeks after childbirth
- One year of psychological or oncologic (cancer) treatment. No coverage may be continued if the doctor is let go from his or her job because they are a danger to their patients, has committed fraud or has been disciplined by the State Board of Medical Examiners.

You have the right to:

- Give instructions about your health care and name someone else to make health care decisions for you. This includes the right to:

1. Make an advance directive about medical care. An advance directive is also known as a living will.

You have the right to:

- Ask questions and get answers and information about your health plan and anything you do not understand. You can also make suggestions. This includes the right to:

1. Get timely notice of changes to your benefits or the status of your doctor.

2. Offer suggestions for changes in policies, procedures and services. This can include your own rights and responsibilities.

3. Look at your medical records at no charge.

4. Be informed in writing if Horizon NJ Health decides to end your membership.

5. Tell Horizon NJ Health when you no longer want to be a member.

You have the right to:

- Appeal a decision 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. Make a complaint about the organization or the care provided using your first language.

2. Know that you or your doctor cannot be punished for filing a complaint or appeal against Horizon NJ Health. Also, you cannot be disenrolled as a member for filing a complaint or appeal against Horizon NJ Health.

3. Contact the Department of Banking and Insurance or the Department of Human Services if you are not satisfied with Horizon NJ Health's decision about a complaint or appeal.

4. Use the Medicaid Fair Hearing process if you are eligible.

Treatment of Minors

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

In certain cases, New Jersey law allows minors to make health care decisions for themselves. Horizon NJ Health will allow treatment of minors when decisions are not made with their parents or guardians 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 Medicaid ID number as head of their household

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

- Talking openly and honestly with your PCP or specialist when telling them about your health
- Seeking care regularly from a doctor to protect your health. This includes making appointments for routine checkups and shots.
- Giving information that is needed to a doctor and Horizon NJ Health so care can be provided to you
- Following your doctor's advice that was agreed on and considering the results if you do not
- Keeping appointments and calling in advance if an appointment must be cancelled
- Reading all Horizon NJ Health member materials and following the rules of membership
- Following the right steps when making complaints about care
- Learning about health issues through education when it is offered
- Paying any copayments or premiums (the amount of money your health plan says you need to pay when getting care) when you have to do so
- Letting the Health Benefits coordinator and Horizon NJ Health know about any doctors you are seeing when you enroll in Horizon NJ Health.

More About Horizon NJ Health

Horizon NJ Health evaluates and approves new technology, including reviewing guidelines from Horizon Healthcare of New Jersey, Inc., leading medical literature and published clinical guidelines and speaking with experts in specific areas, including practicing doctors. We do all of this to make sure that you are receiving the best possible health care.

If you would like a copy of the clinical or preventive guidelines that Horizon NJ Health follows, call Member Services at 1-844-444-4410, TTY: 1-844-889-7700. The guidelines are also on our website at www.horizonNJhealth.com.

We Value Your Opinion

Every few months, Horizon NJ Health hosts a community health advisory meeting with members, community health advocates and community leaders to talk about ways to improve member services, health education and member outreach activities. If you would like to join us at this meeting, call Horizon NJ Health's Marketing & Communications department at 1-844-444-4410 (TTY: 1-844-889-7700) or email communications@horizonNJhealth.com.

Member Satisfaction Survey Results

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

How Your Doctor is Paid

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

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

Medical Decision-Making

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

If you would like more information about how your doctor is paid or decisions are made, call Member Services at 1-844-444-4410, TTY: 1-844-889-7700.

Other Health Insurance

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

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

When You Have Both Medicare and Medicaid (NJ FamilyCare)

IF THE SERVICE IS:	USE THIS TYPE OF DOCTOR:
An approved, Medicare-covered benefit (for example: primary care, lab tests, specialists)	**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 or hearing aids)	**Use a Horizon NJ Health network doctor**

When You Have Other Insurance and Medicaid (NJ FamilyCare)

IF THE SERVICE IS:	USE THIS TYPE OF DOCTOR:
An approved, covered benefit from the other insurance, including referrals from that insurance's PCP, 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**

Horizon NJ Health Managed Long Term Services & Supports Program

The Managed Long Term Services & Supports (MLTSS) program provides services and supports to adults and children to help them perform activities of daily living such as bathing, dressing, eating and toileting, as well as supportive activities such as making meals, shopping, cleaning and laundry. Eligibility for these services is based on multiple pieces of information, including how well a person can perform these basic life tasks. The State of New Jersey, Division of Aging Services, Office of Community Choice Options, makes all final eligibility decisions.

Horizon NJ Health members who are eligible for MLTSS will be assigned a dedicated care manager. The care manager will create a plan of care based on their care needs. Once the plan of care is finished, the care manager will arrange for service providers and for admission to a nursing facility or community residential setting if needed, and follow up with the member to make sure that the services continue to meet care needs.

Horizon NJ Health wishes to provide quality MLTSS that promote independence, dignity, and choice. Horizon NJ Health understands that many people want to stay in their homes as they get older or need help with everyday tasks to be on their own; some cannot afford to pay privately for this help and get most of their help from family, friends and neighbors.

We refer to help from family, friends and neighbors as "informal support." Horizon NJ Health's MLTSS program is NOT intended to replace this valuable assistance but to make it even stronger by offering some support to fill the gaps that cannot be met by family and friends. By offering a flexible package of services based on the member's 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 right or safe for a member to remain in the community. In such situations, the care manager may recommend that the member be placed in a nursing facility or community residential setting.

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

Our multilingual Member Services staff is ready to help you get the most out of your Horizon NJ Health membership. You can call us anytime at 1-844-444-4410. Your case manager will be available Monday through Friday, from 8:00 am to 8:00 pm. At other times, you can call and leave a message for your case manager. When leaving a message, please be sure to give enough detail for us to understand why you are calling. We will return your call within 24 hours.

If you have a hearing or speech impairment and use a TTY/TTD, please call 1-844-889-7700.

Translation Services and Audio/ Visual Information

We have staff members who know many languages. If you speak another language, our customer service representative can use the Language Line service, which has more than 100 languages and dialects.

We can also arrange for a translator to talk over the phone with you and your doctor to help during your doctor's visit. Horizon NJ Health can coordinate a sign language interpreter to be with you at the doctor's office. Translators will make sure that your doctor knows what you are saying and you know what the doctor is saying. With the translator's help, you can get answers to all of your questions.

There is no cost to you to use our translation or sign language interpreter services and they are easy to use. Just call Member Services toll free at 1-844-444-4410, TTY: 1-844-889-7700.

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

Welcome Packet

You will receive a welcome packet when you become enrolled in the Horizon NJ Health MLTSS Program. The welcome packet includes:

- A Welcome Letter
- MLTSS Member Handbook
- Personal Representative Form
- Personal Preference Information
- Important Phone Numbers

Who Qualifies for MLTSS

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

- Be a resident of New Jersey
- Be 65 years old or older, or determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services.
- Qualify for Medicaid financial eligibility by:
  - — Qualifying for SSI in the community, or
  - — Qualifying for Medicaid 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 $4,000).
- Meet clinical eligibility, which is determined by a state or county professional as needing nursing facility level of care
- Reside in an approved community living arrangement
- 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 Medicaid 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). The Office of Community Choice Options (OCCO) makes the final decisions about enrollment into the MLTSS program.

Keeping Your Membership

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

You must renew your Medicaid eligibility annually. You will be notified in writing when it is time to renew your coverage.

MLTSS Member Rights and Responsibilities

You deserve the best health care. As a member of Horizon NJ Health, you have a partner who will help you get the care you need. Horizon NJ Health will treat you with respect, and there are certain rights you can expect from Horizon NJ Health. There are also responsibilities that Horizon NJ Health expects you to live up to.

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

You have the right to:

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

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

1. Provide all health and treatment-related information, including but not limited to, medication, circumstances, living arrangements, and informal and formal supports, to the care manager to identify care needs and develop a plan of care.
2. Understand your health care needs and work with your care manager to develop or change goals and services.
3. Work with your care manager to develop and/or revise your plan of care to facilitate timely authorization and delivery of services.
4. Ask questions when you need more information.
5. Understand the risks that come with your decisions about care.
6. Understand that Horizon NJ Health does not provide 24-hour/seven-day-a-week care management services and that you will need to work with family and friends to safeguard against potential risks.
7. Develop an emergency backup plan for care and services with your care manager.
8. Report any major changes about your health condition, medication, circumstances, living arrangements, informal and formal supports to the care manager.
9. Notify your care manager should any problems occur or if you are not pleased with the services being provided.
10. Pay your room and board in a nursing facility or community residential setting and your cost share on time each month (if applicable).
11. Treat service workers and care providers with dignity and respect
12. Keep all Horizon NJ Health documents, such as your plan of care, emergency backup plan, etc., for your personal records and future reference.
13. Follow Horizon NJ Health's rules and/or those rules of institutional or community residential settings.

MLTSS Care Management

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

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

After your care plan is developed, your care team will help you get all the care and services you need. The care management team will work with you to make appointments. Your care manager will call you at least once a month to check on you. If you need it, your care manager will also come to your home. You will always have your care manager's phone number. You can call to talk to your care team or for help at any time. If you need help after work hours or on weekends, your call will be sent to someone who can help you right away. For example, if you need to know where to go for urgent care, your call will be sent to the on-call staff. If that happens, your care manager will get information about your call to be sure you got what you needed.

Services will be provided to you within 30 calendar days of your enrollment, except for residential modification and vehicle modification. Your care management team will help coordinate your care, such as physician visits, prescription drugs, behavioral health, applying for services and coordinating other health providers. You can participate in your care by sharing your needs and concerns with your care management team so you may continue to live independently in your community.

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

You and your care management team will review your care plan at least every 90 days. The care team may also review your care plan if your condition changes. Horizon NJ Health members must use in-network, contracted providers to get covered MLTSS services.

Horizon NJ Health ensures that its MLTSS care managers work in a conflict-free environment. Care managers cannot work directly with members who are blood relatives or related by marriage. They also cannot be a direct-paid caregiver or be financially responsible for or empowered to make financial or health-related decisions on behalf of a member they are assigned to.

Your Horizon NJ Health MLTSS care manager will call you to introduce him/herself when you join. You have the right to change your case manager. You may do so by telling your case manager or calling Member Services at 1-844-444-4410.

Your Plan of Care

What is a Plan of Care?

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

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

The plan of care will be developed with you and/or your authorized representative, based on your needs. The plan will include unmet needs, personal goals, risk factors, and backup plans.

The plan of care will be signed and dated by you and/or your authorized representative and you will get a copy within 30 days. You will be told about any changes to the plan of care and you must state if you agree or disagree with the following statements:

- I agree with the plan of care.
- I had the freedom to choose the services in the plan of care.
- I had the freedom to choose the providers of my services based on available providers.
- I helped develop this plan of care.
- I am aware of my rights and responsibilities as a member of this program.
- I am aware that the services outlined in this plan of care are not guaranteed.
- I have been told about potential risk factors outlined in this plan of care.
- I understand and accept these potential risk factors.

If you disagree with any of these statements, your concerns will be noted on the plan before you sign it. You must review and sign off on any changes to your plan.

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

Participant Direction and Personal Preference Program

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

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

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

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

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

Pediatric Day Health – A program that provides medical and rehabilitation services to children in a group setting during the day

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

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

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

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

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

Health Care Appointments

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

Bills

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

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

- Been treated for a service not covered by Horizon NJ Health
- Sought care from a non-participating doctor without a referral or authorization from Horizon NJ Health. Horizon NJ Health members cannot "self-refer" to a specialist.
- Received a service not covered by the NJ FamilyCare program

If you get a bill – do not ignore it; call Member Services for instructions

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

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

Horizon NJ Health
Attention: Member Bills
1st Floor
200 Stevens Drive
Philadelphia, PA 19113-1570

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

MLTSS Services

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

Adult Day Health – A program that provides medical and rehabilitation services to adults in a group setting during the day

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

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

Members must need and receive at least one MLTSS service monthly to remain in the program, as well as meet all other requirements listed in the Eligibility section (see page 27).

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 each service. 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.

MLTSS BENEFIT	DESCRIPTION
Adult Family Care	Living in the home of a trained caregiver who provides support and services to the member
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
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
Home-Based Supportive Care	Services that assist with household needs (e.g., meal preparation, laundry)
Home-Delivered Meals	Prepared meals brought to your home
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

These services may be available to you when assessed as a need and identified in your plan of care.

MLTSS BENEFIT	DESCRIPTION
Occupational Therapy (Group and Individual)	Services to help prevent loss of function
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
Residential Modifications	Physical adaptations to a member's private primary residence necessary to ensure health and safety (e.g., wheelchair ramp)
Respite (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
Speech, Language and Hearing Therapy (Group and Individual)	Services to help prevent loss of function
Specialized Medical Equipment and Supplies	
TBI-Behavioral Management (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
TBI-Structured Day Program	Structured day program to assist with the development, independence and community living skills of members with TBI diagnosis
TBI-Supported Day Services	Activities directed at the development of productive activity patterns for members with a TBI diagnosis
Vehicle Modifications	Modifications to a member or family vehicle to allow greater independence

- 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 Heath or the State of New Jersey will notify you of the change within 30 days.

How do I get these services?

To obtain any covered services listed above, talk to your care manager. Your care manager will be able to review and approve most services you need. When you are approved to receive services, we will pay for you to receive the services for a period of time. If we think that you need more or fewer services, your care manager will talk to you about your needs. After that discussion and with your agreement, we may change the amount or type of services you are receiving to keep you independent in the community. Your care plan – with your input – will be updated to reflect these changes.

Who provides these services?

Services, as authorized and arranged by your assigned care manager, may only be given by approved, contracted providers with Horizon NJ Health.

All service providers must meet qualification requirements determined by the State of New Jersey, approved by the federal government (if applicable), and credentialed by Horizon NJ Health.

Reporting Abuse, Neglect or Exploitation

You have the right to be free from exploitation, fraud and abuse. Professionals, including care, are required to report suspected abuse, neglect or exploitation of any:

- Child or adult who resides in a community setting
- Elderly living in nursing homes or other long-term care facilities

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

Adult Protective Services

The New Jersey Adult Protective Services (APS) program has offices in each of the 21 counties. Reports may be made to those County APS offices or to:

The Public Awareness, Information,
Assistance & Outreach Unit
24-Hour Toll-Free Hotline: 1-800-792- 8820

Child Protective Services

The New Jersey Division of Child Protection and Permanency (DCP&P) handles all reports of child abuse and neglect, including those occurring in institutional settings such as child care centers, schools, foster homes and residential treatment centers. These must be reported to the State Central Registry (SCR).

Child Abuse Hotline (SCR)
24-Hour Toll-Free Hotline: 1-877 NJ ABUSE
(1-877-652-2873) TTY: 1-800-835-5510

Facility-Based Complaints and Investigation

Office of the Ombudsman for the Institutionalized Elderly investigates claims of abuse and neglect of people age 60 and older living in nursing homes and other long-term health care facilities, such as assisted living facilities.

24-Hour Toll-Free Hotline: 1-877-582-6995
Email: ombudsman@advocate.state.nj.us

Write:
The Office of the Ombudsman
P.O. Box 852
Trenton, NJ 08625-0852
Fax: 609-943-3479

NJ Division of Health Facilities Evaluation and Licensing investigates all 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

Write:
New Jersey Department of Human Services
Division of Health Facilities Evaluation
and Licensing
P.O. Box 367
Trenton, NJ 08625-0367

Advance Directive

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

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

Proxy Directive
(Durable Power of Attorney for Healthcare)

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

Instruction Directive
(Living Will)

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

Plan Ahead for Emergencies

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

The NJ Office of Emergency Management has a website for residents of NJ with special needs and their families to register. The information will allow emergency responders to better serve them in a disaster or other emergency.

https://www13.state.nj.us/SpecialNeeds/signin.aspx

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

Privacy and Confidentiality

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

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

Fraud, Waste and Abuse

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

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

What is Fraud, Waste and Abuse?

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

Examples of Doctor Fraud, Waste and Abuse

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

Examples of Member Fraud, Waste and Abuse

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

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

If you or someone you know is aware of health care fraud, waste and abuse, you should immediately report it to Horizon NJ Health's Fraud Hotline at 1-855-FRAUD20 (1-855-372-8320), TTY: 1-800-654-5505, or the New Jersey Medicaid Fraud Division at 1-888-937-2835 (TTY: 1-877-294-4356).

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

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

Change of Information

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

You also must contact your County Welfare Office to let them know about the change. If not, you may not get important notices regarding your Medicaid coverage and annual renewal.

Ending Your Membership

The following are reasons you can be disenrolled from Horizon NJ Health's Managed Long Term Services & Supports (MLTSS) program:

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

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

You Can Choose to End Your Membership

Being a Horizon NJ Health member is your choice.

NJ FamilyCare members may end their membership without cause during the first 90 days after the date of enrollment or notice of enrollment (whichever happened later), and then every 12 months during the Open Enrollment Period.

Members may leave Horizon NJ Health with good cause at any time. Good cause reasons include:

- When Horizon NJ Health is not providing services or access to care as agreed on with the New Jersey Division of Medical Assistance and Health Services (DMAHS)
- The member has filed a grievance or appeal against Horizon NJ Health and is not satisfied with the results or if Horizon NJ Health did not respond in a timely manner
- The member has more convenient access to a doctor who participates in another plan in the same enrollment area

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

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

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

When You Leave Horizon NJ Health

- When you leave Horizon NJ Health, you will need to sign your enrollment application to allow us to send your medical records to your new health plan.
- Destroy your Horizon NJ Health ID card. It is very important that you protect your privacy by destroying the old cards so no one can steal your identity or your benefits.
- It will take 30 to 45 days between when you ask to leave and the date your enrollment with Horizon NJ Health ends. Horizon NJ Health or Medicaid will continue to provide services until the disenrollment date.
- If you decide to disenroll voluntarily from Horizon NJ Health, you can list your reasons for leaving in writing.
- Enrollment and disenrollment are always subject to verification and approval by the New Jersey DMAHS.

MLTSS Member Representative

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

The MLTSS member representative is responsible for:

- Internally representing the interests of MLTSS members, but not limited to, input into planning and delivery of long-term services and supports
- Providing education to members, families, and providers on issues related to the MLTSS program
- Assisting you in navigating Horizon NJ Health's system
- Being a resource for you by providing information, making referrals to other staff members, and resolving issues.

You can reach the member representative Monday through Friday from 8 a.m. to 8 p.m. by calling 1-844-444-4410.

Your Right to Choose

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

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

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

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

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

Nursing Facility to Community Transition

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

If it is determined that you can safely and cost-effectively move from the nursing facility back to the community, you may be able to use the Community Transition Services benefit. This service aids in the transition from an institutional setting to your own home in the community by covering transitional expenses. This benefit can only be used one time and has a limit of $5,000.

Allowable expenses are those needed for a person to establish a basic household that do not constitute room and board and may include, but are not limited to:

- Security deposits required to get a lease on an apartment or home
- Necessary household furnishings and moving expenses required for a community residence, including furniture, window coverings, food preparation items and bed/bath linens
- Moving expenses

Community Transition Services does NOT include items such as:

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

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

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

Money Follows the Person

Members who are determined eligible to move from an institution to the community may be eligible for the Money Follows the Person (MFP) program.

The MFP program is a grant that helps states rebalance their Medicaid long-term care systems and helps more people move out of institutions into the community. The MFP program increases the use of home and community-based services and reduces the use of institutionally-based services. It also strengthens the ability of Medicaid programs to provide home and community-based services to people who choose to transition out of institutions. The program participation period is for 365 calendar days.

Participation in the MFP program is voluntary. Your case manager will discuss the program with you if you appear to qualify and ask you if you are interested in participating. They will assess if you meet criteria for the program. You will have to sign a form stating that you are interested in participating in the program.

You will also be asked to participate in two Quality of Life surveys to determine if you feel good about living in the community after living in an institution. Someone will contact you or visit you to ask you these questions.

Complaint/Grievance and Appeal Procedures

Horizon NJ Health has a complaint procedure for resolving disagreements between members, doctors and/or Horizon NJ Health. Disputes may involve Horizon NJ Health's benefits, the delivery of services or Horizon NJ Health's operation. This procedure includes both Utilization Management (UM) and non-UM issues. A complaint, by phone or in writing, can usually be resolved by contacting Member Services. The notification of grievance and appeal rights shall be in your primary language. You may file your grievance and/or appeal in your primary language. You will also receive the decision in your primary language. Issues regarding emergency care will be addressed immediately. Issues regarding urgent care will be addressed within 48 hours in your primary language. Horizon NJ Health will not discriminate against a member or attempt to disenroll a member for filing a complaint grievance or appeal.

Complaint – a formal charge against Horizon NJ Health filed when a member or doctor does not agree with the type of service given or not given

Complaint/Grievance Procedure

If you have a complaint, call 1-844-444-4410, TTY: 844-889-7700 to talk about it with one of our Member Services representatives. If you want, you may send a written complaint to:

Horizon NJ Health
Attn: Member Complaints
200 Stevens Drive
Philadelphia, PA 19113-1570

Members may also submit a verbal or written complaint directly to the Department of Banking and Insurance by phone at 1-609-292-5316, by fax at 1-609-292-5865 or by using the online complaint form at www.state.nj.us/dobi/enfcon.htm.

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

1. A Member Services representative will be available to discuss and resolve your complaint. If you submit a complaint by mail, a Member Services representative will try to contact you by telephone within 24 hours of receipt of the complaint to discuss and resolve your complaint. The representative will document all the information discussed with you on an electronic form.
2. If you are not satisfied with the resolution from the Member Services representative, tell the representative and the complaint will be forwarded to Horizon NJ Health's complaint coordinator for further investigation.
3. The complaint coordinator will investigate the complaint and you will be notified in the following time frames:

- If the complaint is resolved within five business days, you will get verbal notification. If Horizon NJ Health cannot reach you through a telephone call, you will get written notification about the outcome.
- If the complaint is not resolved within five business days, your issue will be treated as a grievance. You will get written notification about the outcome within 30 days of receipt of the complaint.

Appeals

You or your doctor (with your written approval) have the right to ask Horizon NJ Health to review and change our decision if we have denied or reduced your benefits. This is called an appeal. An appeal can be oral or written. All appeals must be submitted within 90 days of receipt of the denial determination. Please follow the appeal process described below.

You also have the right to ask Medicaid to review Horizon NJ Health's decision about your service. This is called a Medicaid Fair Hearing. You may request a Medicaid Fair Hearing at any time during the appeal process; however, you must request a Medicaid Fair Hearing within 20 days of a denial determination.

Appeal Process

The appeal process has three stages. In Stage 1 and Stage 2, Horizon NJ Health will review its decision about the services you asked for. If you are not happy with our decision at the end of Stage 2, or if Horizon NJ Health's decision was not made by the deadline set for each stage, you may ask to have your request reviewed by someone outside of Horizon NJ Health. This is a Stage 3 external appeal.

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

- Your appeal is filed in a timely fashion
- The service was previously approved by Horizon NJ Health
- The service was ordered by an authorized provider

You may ask for a copy of the benefit provision, guideline, protocol or other criterion on which the appeal decision was based. You can also request copies of all the documents related to your appeal

Stage 1 Appeal

Your appeal must be started no later than 90 days after the date of the denial letter sent to you. You or your doctor must:

- Call Horizon NJ Health toll free at 1-844-444-4410, TTY: 844-889-7700, or
- Fax your letter to the Appeals department at 1-609-583-3028, or
- Send us a letter to:

Horizon NJ Health
Appeals Coordinator
210 Silvia Street
West Trenton, NJ 08628

Let us know:

1. Your name and Horizon NJ Health ID number
2. Your doctor's name
3. That you want to appeal our decision
4. The reason you want to appeal
5. If the services are for urgent or emergency treatment

Horizon NJ Health must get back to you with a decision within 10 calendar days. If your appeal is about services for urgent or emergency treatment, we will tell you the results of your appeal within 72 hours (three days – weekends and holidays count).

If we do not approve the services you are asking for in your appeal, Horizon NJ Health will send you a letter and explain why. We will also tell you how to file a Stage 2 appeal.

Stage 2 Appeal

If you want to appeal Horizon NJ Health's denial of your Stage 1 appeal, then as soon as you can, but no later than 90 days after you receive the written denial of your Stage 1 appeal, you or your doctor must:

- Call Horizon NJ Health toll free at 1-844-444-4410, TTY: 844-889-7700, or
- Fax your letter to the Appeals department at 1-609-538-3028, or
- Send us a letter to:

Horizon NJ Health
Appeals Coordinator
210 Silvia Street
West Trenton, NJ 08628

Let us know:

1. Your name and Horizon NJ Health ID number
2. Your doctor's name
3. That you want to appeal our decision
4. The reason you want to appeal
5. If the services are for urgent or emergency treatment

Horizon NJ Health will send you a letter letting you know that we have your appeal request. This will be done within 10 business days (weekends and holidays do not count) after we get your phone call or letter.

We will get back to you with a decision on your appeal within 20 business days. If your appeal is about services for urgent or emergency treatment, we will get back to you within 72 hours (three days – weekends and holidays count).

At this appeal level, you are allowed to present important information about your appeal directly to the Appeals Subcommittee, either in person or by telephone.

If we do not approve the services you are asking for in your Stage 2 appeal, Horizon NJ Health will send you a letter explaining why. The letter will also let you know how to file a Stage 3 external appeal. If you wish to appeal certain benefits, such as Adult Family Care, Assisted Living Program, Assisted Living Services, Caregiver/participant training, Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, PCA, Respite (daily and hourly), Social Day Care, Structured Day Program, and Supported Day Services (when the denial is not based on the

diagnosis of TBI), administered by the Personal Preference Program, the medical necessity of the service may not be the issue, and the Stage 3 External Appeal process may not apply. In these cases, please use the Medicaid Fair Hearing process explained on page 47. Please note that these types of appeals cannot be pursued through a Stage 3 External Appeal.

Stage 3 External Appeal

If you want to appeal the denial of your Stage 2 appeal, you may ask that someone outside of Horizon NJ Health review your request for service. This is done by an Independent Utilization Review Organization (IURO). Within four months of getting Horizon NJ Health's written notice of denial, you or your doctor must fill out the form called Application for the Independent Health Care Appeals Program, sent to you with the results of your Stage 2 appeal decision from Horizon NJ Health. Be sure to sign the form. Your signature allows the IURO to review your medical records and other medical information that may be needed for your appeal.

The IURO will give you its decision within 45 days after it gets all the materials it needs to make a decision. You may present your information about your case directly to the Appeals Committee either in person or by telephone. You may have someone come with you to the proceedings.

If your appeal is about services for urgent or emergency treatment, you should call the DOBI at 1-609-292-5316, extension 50998, or call toll-free at 1-888-393-1062 and ask that your appeal be reviewed within 48 hours (two days – weekends and holidays count). You still must complete the form.

Horizon NJ Health must accept the decision of the IURO.

Medicaid Fair Hearing

In addition to your right to Horizon NJ Health's appeal process, you may have the right to ask the New Jersey Division of Medical Assistance and Health Services to review Horizon NJ Health's decision about your service. This is known as a Medicaid Fair Hearing.

If you want to ask for a Medicaid Fair Hearing, as soon as you can, but no later than 20 calendar days from the date of Horizon NJ Health's denial letter, you must send a letter to Medicaid at:

New Jersey Department of Human Services
Division of Medical Assistance
and Health Services
Medicaid Fair Hearing Section
P.O. Box 712
Trenton, NJ 08625-0712

Let Medicaid know in your letter:

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

If you want to continue getting the benefits in question during the appeal process, you must request to do so in writing within 20 days of the date of the denial letter or prior to the intended effective date of the HMO proposed action, whichever is later. If you request continued benefits and your appeal is denied, you may have to pay the cost of the services.

At the hearing, someone outside of Horizon NJ Health and Medicaid will review your request for services. This person is a judge from the Office of Administrative Law (OAL), who will listen to you and others who speak for or with you at the hearing. You have the right to be at the Medicaid Fair Hearing or have a lawyer, friend or other person go with or for you.

The OAL judge will give Medicaid an opinion on your request and Medicaid will then decide whether to accept or deny your request. Medicaid will give you its decision within 90 days, unless your request is for urgent or emergency treatment.

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

Further Assistance

You may also get assistance by contacting the Department of Banking and Insurance (DOBI), which assists covered persons with claims, internal appeals, and external appeals. You can reach DOBI by calling 1-800-446-7467.

Interdisciplinary Team (IDT) Meeting

The Interdisciplinary Team (IDT) includes your care manager, the care manager's supervisor, a Horizon NJ Health medical director, the behavioral health administrator (if appropriate), the 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. The IDT will meet when your care plan changes, or you ask for a change to your care plan, and one of the following applies:

- You ask to receive your care in a home or community-based setting, but it is not cost-effective for you to receive the care you need in a home or community-based setting.
- You ask to receive your care in a nursing home or other long-term care facility, but it is not cost-effective for you to live in a nursing home or other long-term care facility.
- Your care plan has been changed to meet your health and welfare needs. However, the services you need can no longer be provided in your current setting in a way that is cost effective.
- Your care plan has been changed to meet your needs. However, the services you need can no longer be provided in your current setting in a way that is safe or effective.

You have the right to ask for an Interdisciplinary Team (IDT) meeting. In cases where one of the situations listed above applies, your MLTSS care manager will schedule a meeting to discuss your care plan within seven (7) days. During the IDT meeting, the cost effectiveness limitations of the program will be discussed, as well as the different options available in terms of services and settings, such as Nursing Facility settings and services provided in home and community-based settings. During the meeting you will be told of the decision verbally.

If at the end of the IDT meeting you are still not satisfied with the outcome, you have the right to request a Medicaid Fair Hearing. The Appeals Department will send you a letter with the IDT outcome. The IDT outcome letter will include your Medicaid Fair Hearing rights and application form. For more details on the Fair Hearing process, please refer to page 47.

Horizon Blue Cross Blue Shield of New Jersey

Horizon NJ Health

210 Silvia Street
West Trenton, NJ 08628
1-844-444-4410
TDD/TTY: 1-844-889-7700

horizonNJhealth.com

Si desea recibir un ejemplar en español del manual para los miembros de Horizon NJ Health, llame a Servicios para Miembros, sin cargo, al 1-844-444-4410. Esta oficina atiende durante las 24 horas, todos los días.

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