Horizon NJ TotalCare (HMO D-SNP) *Evidence of Coverage*

January 1 – December 31, 2024

Your Health and Drug Coverage under Horizon NJ TotalCare (HMO D-SNP)

Evidence of Coverage Introduction

This *Evidence of Coverage,* otherwise known as the *Member Handbook,* tells you about your coverage under our Plan through December 31, 2024. It explains health care services, including behavioral health (mental health and substance use disorder treatment) services, prescription drug coverage, and Managed Long-Term Services and Supports (MLTSS). Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Evidence of Coverage*.

This is an important legal document. Keep it in a safe place.

This plan, Horizon NJ TotalCare (HMO D-SNP), is offered by Horizon Healthcare of New Jersey, Inc. When this *Evidence of Coverage* says "we," "us," or "our," it means Horizon Healthcare of New Jersey, Inc. When it says "plan" or "our Plan," it means Horizon NJ TotalCare (HMO D-SNP).

This document is available for free in Spanish.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

- To request materials in a language other than English and/or an alternate format, please call Member Services at **1-800-543-5656** (TTY users should call **711**) 24 hours, 7 days a week. The call is free.

- Your preferred language and/or format request is captured at the time of enrollment and we will keep your language/preference on file for future requests. You can also make a standing request for materials to be in Spanish and/or in a particular format. This will be sent by mail or other available methods. You have the option to change your preference at any time by calling Member Services at 1-800-543-5656 (TTY 711), 24 hours a day, 7 days a week.

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- We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at **1-800-543-5656**. Someone that speaks your language can help you. This is a free service.

- Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-543-5656. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

- 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-543-5656。我们的中文工作人员很乐意帮助您。这是一项免费服务。

- **您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電** 1-800-543-5656。**我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。**

- Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-543-5656. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

- Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-543-5656. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

- Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-543-5656 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

- Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-543-5656. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

- 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-543-5656번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

- Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-543-5656. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

- إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-543-5656. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

- हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-543-5656 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

- È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-543-5656. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

- Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-543-5656. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

- Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-543-5656. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

- Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-543-5656. Ta usługa jest bezpłatna.

- 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-543-5656にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

When joining this plan:

1. You must use in-network providers, DME (Durable Medical Equipment) suppliers, and pharmacies.

2. You will be enrolled automatically into Medicaid (NJ FamilyCare) coverage under our Plan, and disenrolled from any Medicaid (NJ FamilyCare) plan you are currently enrolled in. All of your Medicaid-covered services, items, and medications will then be covered under our Plan, and you must get them from in-network providers.

3. You will be enrolled automatically into Part D coverage under our Plan, and you will be automatically disenrolled from any other Medicare Part D or creditable coverage plan in which you are currently enrolled.

4. You must understand and follow our Plan's rules on referrals.

Disclaimers

- Coverage under Horizon NJ TotalCare (HMO D-SNP) is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information on the individual shared responsibility requirement.

- Products are provided by Horizon NJ Health. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both are independent licensees of the Blue Cross Blue Shield Association.

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Chapter 1: Getting started as a member

Introduction

This chapter includes information about Horizon NJ TotalCare (HMO D-SNP), a health plan that covers all of your Medicare and NJ FamilyCare (Medicaid) services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Welcome to our Plan

Our Plan provides Medicare and NJ FamilyCare (Medicaid) services to individuals who are eligible for both programs. Our Plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

B. Information about Medicare and NJ FamilyCare (Medicaid)

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. NJ FamilyCare

NJ FamilyCare is the name of the New Jersey Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. NJ FamilyCare helps people with limited incomes and resources pay for MLTSS and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of New Jersey approved our Plan. You can get Medicare and NJ FamilyCare services through our Plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of New Jersey allow us to continue to offer this plan.

Even if our Plan stops operating in the future, your eligibility for Medicare and NJ FamilyCare services is not affected.

C. Advantages of our Plan

You will now get all your covered Medicare and NJ FamilyCare services from our Plan, including prescription drugs. **You do not pay anything to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care manager. This is a person who works with you, with our Plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care manager.
- Your care team and care manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our Plan's service area

Horizon NJ TotalCare (HMO D-SNP) is available only to individuals who live in our Plan's service area. To remain a member of our Plan, you must continue to reside in the plan service area. The service area is described below.

Service Area		
1. Atlantic	8. Gloucester	15. Ocean
2. Berger	9. Hudson	16. Passaic
3. Burlington	10. Hunterdon	17. Salem
4. Camden	11. Mercer	18. Somerset
5. Cape May	12. Middlesex	19. Sussex
6. Cumberland	13. Monmouth	20. Union
7. Essex	14. Morris	21. Warren

Only people who live in our service area can join our Plan.

You cannot stay in our Plan if you move outside of our service area. Refer to **Chapter 8** of your *Evidence of Coverage* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our Plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for NJ FamilyCare.

If you lose eligibility but can be expected to regain it within 60 days (2 full calendar months) then you are still eligible for our Plan.

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our Plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care manager, or other health person that you choose.

A care manager is a person trained to help you manage the care you need. You get a care manager when you enroll in our Plan. This person also refers you to other community resources that our Plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care manager and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and MLTSS or other services.

Your care plan includes:

- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Your monthly costs for Horizon NJ TotalCare (HMO D-SNP)

Our Plan has no premium.

H1. Monthly Medicare Part B Premium

Medicaid pays your Medicare Part B premium for you when you are enrolled in this plan.

I. Your *Evidence of Coverage*

Your *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Evidence of Coverage* or call **1-800-MEDICARE (1-800-633-4227).**

You can ask for an *Evidence of Coverage* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website **www.HorizonBlue.com/Medicare**.

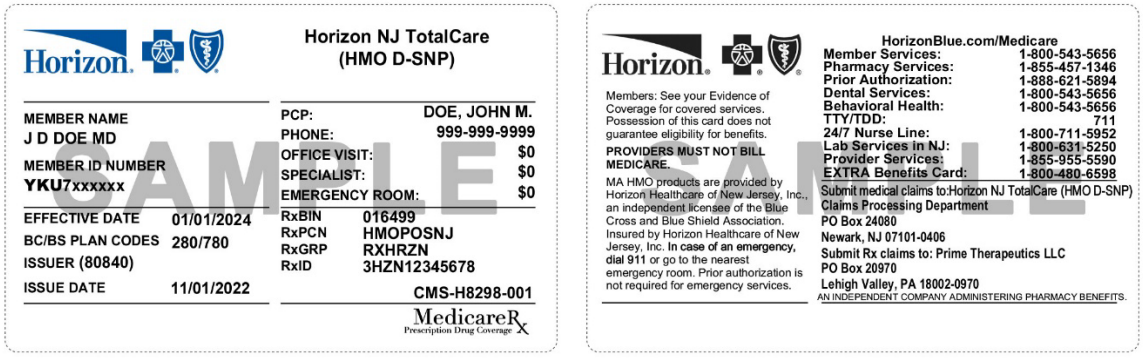
The contract is in effect for the months you are enrolled in our Plan between January 1, 2024 and December 31, 2024.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory,* and information about how to access a *List of Covered Drugs,* also known as a *Formulary*.

J1. Your Member ID Card

Under our Plan, you have one card for your Medicare and NJ FamilyCare services, including MLTSS, behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our Plan, you do not need to use your red, white, and blue Medicare card or your NJ FamilyCare card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our Plan, and you may get a bill. Refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do if you get a bill from a provider.

J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers, pharmacies, and durable medical equipment suppliers in our Plan's network. While you're a member of our Plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at **HorizonBlue.com/doctorfinder**.

The *Provider and Pharmacy Directory* lists our network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which our Plan authorizes use of out-of-network providers. If you don't have your copy of the Provider and Pharmacy Directory, you can request a copy from Member Services.

The Provider and Pharmacy directory lists our network pharmacies. Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our Plan members. You can use the Provider and Pharmacy Directory to find the network pharmacy you want to use. See **Chapter 5**, Section A8 for information on when you can use pharmacies that are not in the plan's network.

The plan allows at least 90 days for transition and continuity of care for new members undergoing an active course of treatment or when a member's provider leaves the network to prevent any disruptions in care.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy from Member Services.

Definition of network providers

- Our network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our Plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our Plan; **and**
    - MLTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our Plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our Plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our Plan to pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Durable Medical Equipment (DME)

We sent you our List of DME with this *Evidence of Coverage*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Evidence of Coverage* to learn more about DME equipment.

J3. List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells you which prescription drugs our Plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take. **Chapter 6** of your *Evidence of Coverage* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get**.

Tell us right away about the following:

- changes to your name, your address, or your phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Evidence of Coverage*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our Plan and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

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A. Member Services

CALL	**1-800-543-5656**. This call is free. Hours of Operation: 24 hours a day, 7 days a week. **For Prescription Drugs**: **1-855-457-1346** Hours of Operation: 24 hours a day, 7 days a week. For **Horizon Extra Benefits Card- Member Services**, please call **1-800-480-6598** We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. Hours of Operation: 24 hours a day, 7 days a week.
WRITE	Horizon NJ TotalCare (HMO D-SNP) Member Services P.O. Box 24081 Newark, NJ 07101-0406 **For Prescription Drugs**: Prime Therapeutics, LLC 10802 Farnam Drive Omaha, NE 68154 **Horizon Extra Benefits Card** Member Services 4613 N. University Dr. #586 Coral Springs, FL 33067
WEBSITE	**HorizonBlue.com/Medicare**

	Coverage Decisions, Appeals or Complaints for Medical Care– Contact Information
FAX	**Medical appeal requests can be faxed to**: **609-583-3028** **Complaints and non-contracted provider claim appeals requests can be faxed to**: **732-938-1340**
WRITE	**Written medical appeal requests should be mailed to the following address:** Horizon NJ TotalCare Medical Appeals P.O. Box 10196 Newark, NJ 07101-0406 **Written non-contracted provider claim appeals requests should be mailed to the following address:** Horizon NJ TotalCare P.O. Box 24079 Newark, NJ 07101-0406 **Written complaints about medical care should be mailed to the following address:** Horizon NJ TotalCare Appeals and Grievances 3 Penn Plaza PP-12L Newark, NJ 07101-0406 **Written Grievances about medical care should be mailed to the following address:** DSNP Written Grievance PO Box 24079 Newark NJ 07101-0406 **Written HIPAA Privacy Grievances about medical care should be mailed to the following address:** Privacy Office Three Penn Plaza East PP-16C Newark NJ 07105-2200

	Coverage Decisions or Appeals for Part D Prescription Drugs – Contact Information
CALL	**1-855-457-1346** Calls to this number are free. Hours of Operation: 24 hours a day, 7 days a week.
TTY	**711** Calls to this number are free. Hours of Operation: 24 hours a day, 7 days a week.
FAX	**1-800-693-6703**
WRITE	Prime Therapeutics, LLC Clinical Review Department 2900 Ames Crossing Road Eagan, MN 55121
WEBSITE	**HorizonBlue.com/Medicare**

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - your benefits and covered services.
    - Call us if you have questions about a coverage decision about your health care.
    - To learn more about coverage decisions, refer to **Chapter 9** of your *Evidence of Coverage*.
- appeals about your health care
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.

- To learn more about making an appeal, refer to **Chapter 9** of your *Evidence of Coverage* or contact Member Services.

- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our Plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D**).
  - You can call us and explain your complaint at **1-800-543-5656**
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our Plan to Medicare. You can use an online form at **www.medicare.gov/MedicareComplaintForm/home.aspx**. Or you can **call 1-800-MEDICARE (1-800-633-4227)** to ask for help.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Evidence of Coverage*.

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs.
  - This applies to your Medicare Part D drugs and NJ FamilyCare covered drugs and over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.

- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.

- complaints about your drugs
    - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
    - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section below.)
    - You can send a complaint about our Plan to Medicare. You can use an online form at **www.medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)** to ask for help.
    - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.
- payment for health care or drugs you already paid for
    - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 9** of your *Evidence of Coverage*.
    - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Evidence of Coverage.*

B. Your Care Manager

CALL	**1-888-621-5894** (option **2**) This call is free. Hours of Operation: Monday – Friday, between 9:00 a.m. – 5:00 p.m. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free.
WRITE	Horizon NJ TotalCare (HMO D-SNP) Care Management Department 1700 American Boulevard Pennington, NJ 08534
WEBSITE	**HorizonBlue.com/Medicare**

Contact your care manager to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder treatment) services
- questions about transportation
- questions about Managed Long Term Services and Supports (MLTSS)

C. State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In New Jersey, the SHIP is called the State Health Insurance Assistance Program (SHIP).

The SHIP is not connected with any insurance company or health plan.

CALL	**1-800-792-8820** Hours of Operation: Monday – Friday, between 8:30 a.m. – 4:30 p.m.
TTY	**711**
WRITE	NJ State Health Insurance Assistance Program PO Box 807 Trenton NJ 08625-0807
WEBSITE	**www.state.nj.us/humanservices/doas/services/ship/**

Contact SHIP for help with:

- questions about Medicare
- SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our Plan.

CALL	**1-866-815-5440** Hours of Operation: Monday – Friday, between 9:00 a.m. – 5:00 p.m. (local time to the patient); weekends/holidays, between 11:00 a.m. – 3:00 p.m. (local time for appeals). Additionally, 24-hour voicemail service is available.
TTY	**1-866-868-2289** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	**www.livantaqio.com/en/states/new_jersey**

Contact Livanta for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048**. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	**www.medicare.gov** This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

F. NJ FamilyCare (Medicaid)

NJ FamilyCare helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the NJ Department of Human Services, Division of Medical Assistance and Health Services.

Because you are eligible for and enrolled in both Medicare and Medicaid, your coverage through our Plan includes coverage for all of the benefits you are entitled to under Medicaid managed care (NJ FamilyCare). As a result, our Plan covers all of your Medicaid benefits, such as hearing aids, routine vision exams, and comprehensive dental services. Additionally, Medicaid pays your Part B premium for you.

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, enrolled in Medicare Part B, and be eligible for Full NJ FamilyCare Benefits.

Our Plan is designed to meet the needs of people who are eligible for both Medicare and NJ FamilyCare.

CALL	NJ Department of Human Services, Division of Medical Assistance and Health Services **1-800-701-0710** Hours of Operation: Monday – Friday, between 8:30 a.m. – 5:00 p.m.
TTY	**711**
WRITE	NJ Department of Human Services Division of Medical Assistance and Health Services PO Box 712 Trenton, NJ 08625-0712
WEBSITE	**www.state.nj.us/humanservices/dmahs/**

G. Office of the Insurance Ombudsman

The Office of the Insurance Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Insurance Ombudsman also helps you with service or billing problems. They are not connected with our Plan or with any insurance company or health plan. Their services are free.

CALL	**1-800-446-7467** Hours of Operation: Monday – Friday, between 8:30 a.m. – 5:00 p.m.
TTY	**711**
WRITE	The Office of the Insurance Ombudsman NJ Department of Banking and Insurance PO Box 472 Trenton NJ 08625-0472
WEBSITE	**www.state.nj.us/dobi/ombuds.htm**

H. New Jersey Office of the State Long-Term Care Ombudsman

The New Jersey Office of the State Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The New Jersey Office of the State Long-Term Care Ombudsman is not connected with our Plan or any insurance company or health plan.

CALL	**1-877-582-6995** Hours of Operation: Monday – Friday, between 8:00 a.m. – 4:00 p.m.
TTY	**711**
WRITE	NJ Long-Term Care Ombudsman P.O. Box 852 Trenton, NJ 08625-0852
WEBSITE	**www.nj.gov/ooie/**

I. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website (**www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs**) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this "Extra Help."

CALL	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	**www.medicare.gov**

J. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S Citizens and lawful permanent residents who are 65 and over, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

CALL	**1-800-772-1213** Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Social Security Administration Office of Public Inquiries and Communications Support 1100 West High Rise 6401 Security Blvd. Baltimore, MD 21235
WEBSITE	**www.ssa.gov**

K. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive Medicare through the RRB, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the RRB, contact the agency.

CALL	**1-877-772-5772** Calls to this number are free. If you press "0", you may speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are *not* free.
WEBSITE	**www.rrb.gov**

L. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You may also call **1-800-MEDICARE (1-800-633-4227;** TTY: **1-877-486-2048)** with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our Plan.

Chapter 3: Using our Plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our Plan. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

For the details on what medical care and other services are covered by our Plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered*).

Table of Contents

A. Information about services and providers

Services are health care, Managed Long-Term Services and Supports (MLTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our Plan pays for. Covered health care, behavioral health, and MLTSS are in **Chapter 4** of your *Evidence of Coverage*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Evidence of Coverage.*

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain MLTSS.

Network providers are providers who work with our Plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our Plan covers

Our Plan covers all services covered by Medicare and NJ FamilyCare. This includes behavioral health and Managed Long Term Services and Supports (MLTSS).

Our Plan will generally pay for health care services, behavioral health services, and MLTSS you get when you follow our rules. To be covered by our Plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
    - In most cases, your network PCP must give you approval before you can use a provider that is not your PCP or use other providers in our Plan's network. This is called a **referral**. If you don't get approval, we

may not cover the services. To learn more about referrals, refer to page 37.

- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to section D1 in this chapter).

- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:

  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to Section H in this chapter).

  - If you need care that our Plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Prior authorization must be obtained for services rendered by an out-of-network provider. In this situation, we cover the care at no cost to you.

  - We cover kidney dialysis services when you're outside our Plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.

  - Family Planning services may be obtained via out-of-network providers; in these cases, the services will be covered directly via NJ FamilyCare fee-for-service.

C. Your Care Manager

C1. What a care manager is

A care manager is a person trained to help you manage the care you need. You get a care manager when you enroll in our Plan. This person also refers you to other community resources that our Plan may not provide and will work with your care team to help coordinate your care.

C2. How you can contact your care manager

If you have questions about our Care Management program, call **1-888-621-5894** (TTY **711**) and select option **2**. Representatives are available Monday through Friday from 8 a.m. to 5 p.m., Eastern Time.

C3. How you can change your care manager

To change your care manager, please call **1-888-621-5894** (**TTY 711**) and select option **2.**

D. Care from providers

D1. Care from a primary care provider (PCP)

When you become a member of our Plan, you must choose a network provider from our *Provider and Pharmacy Directory*, to be your PCP.

Definition of a PCP and what a PCP does do for you

Your PCP is a physician specializing in Family Practice, General Practice, Geriatric Medicine or Internal Medicine who meets state requirements and is trained to give you basic medical care. As we explain below, you will obtain your routine or basic care from your PCP. Your PCP will also coordinate the rest of your covered services.

If required, your PCP will request a prior authorization for services requiring authorization. If your PCP sends you to a specialist, your specialist will also request a prior authorization for services requiring authorization.

Your choice of PCP

When you joined our Plan, you were asked to choose a PCP from our *Provider and Pharmacy Directory*. If you have not chosen a PCP, a PCP will be assigned for you. You can select a PCP by calling Member Services at **1-800-543-5656**, 24 hours a day, seven days a week. After choosing your PCP, you will receive an ID card in the mail with your PCP's name on it.

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our Plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

You may call Member Services to change your PCP at any time. Member Services will also ensure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. If you saw your current PCP on the date you call to change your PCP, the change to the new PCP will take place on the next calendar day. Otherwise, the

change will take place on the day you call. If your PCP leaves our Plan, we will let you know and help you choose another PCP.

- You will receive notification if your PCP leaves our network. Members who change their PCP are not limited to specific specialists or hospitals to which the PCP refers, however, treatment must be rendered by a network specialist or hospital.

Under certain circumstances, you may continue receiving covered services from a participating physician or other health care professional who has left the network for up to four months beyond the effective date of termination (the end of the notice period).

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

  - Pregnancy – up to the postpartum evaluation (up to six weeks after delivery).
  - Post-operative follow-up care (up to six months).
  - Oncological treatment (up to one year).
  - Psychiatric treatment (up to one year).

Please see Chapter 4 for a description of your benefits and any authorization requirements that may apply to them.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- emergency services from network providers or out-of-network providers
- urgently needed care from network providers
- urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our Plan's service area or during the weekend)

  Note: Urgently needed care must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our Plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations.

- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- All preventive services
- All specialist services

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.
- **You do not need a referral from your PCP to see a network specialist.**
- Your Plan, Horizon NJ TotalCare (HMO D-SNP), offers a participating provider network. You can view the *Provider and Pharmacy Directory* at **HorizonBlue.com/doctorfinder**. You may also call Member Services for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. For some types of services, you or your provider may need to get approval in advance from our Plan (this is called getting "prior authorization"). If your PCP determines that a prior authorization is needed, the PCP will contact the plan at **1-888-621-5894**. (TTY users should call **711**.) Please refer to Chapter 4, Section C, for services that require prior authorization from our Plan.
- Should you need to be treated after hours or on weekends, your physician or his/her covering physician is available 24 hours a day, every day.
- The selection of a PCP does not limit a member to specific specialists or hospitals to which the PCP refers, however, treatment must be rendered by a network specialist or hospital.

If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;

- a degenerative disease or disability;
- any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.

D3. When a provider leaves our Plan

A network provider you use may leave our Plan. If one of your providers leaves our Plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our Plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our Plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our Plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- Under certain circumstances, you may continue receiving covered services from a provider who has left our network for up to four months beyond the effective date of termination (the end of the notice period).
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues. If you are undergoing certain courses of treatment, you may be able to receive longer periods of care as indicated below:
        - Pregnancy: up to the postpartum evaluation -- up to six weeks after delivery.

  - Post-operative follow-up care (care given after surgery): (up to six months).
  - Oncological treatment (treatment for cancer): up to one year.
  - Psychiatric treatment (mental health treatment with a psychiatrist): up to one year.

- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization must be obtained for services rendered by an out-of-network provider.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

Under certain circumstances, for up to four months beyond the effective date of termination (the end of the notice period), you may continue receiving covered services from a provider who has left our network.

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- pregnancy – up to the postpartum evaluation (up to six weeks after delivery)
- post-operative follow-up care (up to six months)
- oncological treatment (up to one year)
- psychiatric treatment (up to one year)

If you find out one of your providers is leaving our Plan, contact us. We can assist you in finding a new provider and managing your care. Call Member Services at the number at the bottom of the page for assistance.

D4. Out-of-network providers

Members are entitled to receive services from out-of-network providers for emergency or out-of-area urgently needed services. Dialysis services for ESRD members who traveled outside the plan's service area and are not able to access contracted ESRD providers will be covered. Family Planning services may be obtained via out-of-network providers; in these cases, the services will be covered directly via NJ FamilyCare fee-for-service.

If the necessary expertise does not exist within our Plan's network, or there is no available participating physician, other health care professional, or facility to provide a medically necessary service that you are in need of, we can arrange for appropriate out-of-network care to be covered for you.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or NJ FamilyCare.

- We cannot pay a provider who is not eligible to participate in Medicare and/or NJ FamilyCare.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. Managed Long-term services and supports (MLTSS)

A member must meet certain clinical and financial requirements to be eligible for MLTSS. The MLTSS program includes services for members who need the level of care typically provided in a nursing facility, and provides the support needed to allow them to receive the care they need in their home or community as long as possible. This includes services such as meal delivery, personal emergency response system and residential modification (such as ramp installation), among others. Ask your care manager for more information.

F. Behavioral health (mental health and substance use disorder treatment) services

Contact the Horizon behavioral health program at **1-800-543-5656,** between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**.

G. How to get self-directed care through the Personal Preference Program (PPP)

G1. What self-directed care is

- Self-directing emphasizes independence and empowerment by expanding your degree of choice and control over your long term services and supports. It allows you and your authorized program representative to serve as the employer and take responsibility for directly hiring, training, supervising, and firing your paid workers. You and your authorized program representative become the experts on your own care and are able to determine the services and supports that best meet your personal care needs. The Personal Preference Program (PPP) offers you greater control, flexibility, and freedom. You can choose who provides your care, what type of care you want and need, when you want care to be provided and where the care will be provided. Workers become accountable to you/authorized program representative.

G2. Who can get self-directed care

- Eligibility for Self-Directed Services:
  - For members that require assistance with activities of daily living;
  - For individuals currently receiving (or who are eligible to receive) Medicaid PCA services from a home health agency;
  - Requires that participants have the ability to direct and manage services, or choose a representative that can assist them with the program.

G3. How to get help in employing personal care providers

- You will have an assigned financial consultant who will help you with navigating the program. Consultants serve as trainers, resource-locators and advisors. Consultants regularly check-in and answer any questions you may have for as long as you remain enrolled in the PPP.

H. Transportation services

Non-emergency transportation, such as mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage), are covered directly by NJ FamilyCare Fee-for-Service. All non-emergency transportation is arranged through the state's transportation vendor, Modivcare. To schedule transportation, call Modivcare

at **1-866-527-9933**. You can also ask your PCP or Care Manager to help you to arrange this service. Routine (non-emergent) transportation is paid for directly by the State through NJ FamilyCare (Medicaid) Fee-for-Service, and is arranged through Modivcare, the State's transportation vendor. You can arrange transportation by contacting Modivcare directly, or your PCP/provider or Care Manager may make the arrangements on your behalf.

- Transportation must be arranged by 12 noon at least two (2) business days in advance of transportation need by calling **1-866-527-9933** unless the provider indicates the appointment is urgent.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
    - There is not enough time to safely transfer you to another hospital before delivery.
    - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license.

- **As soon as possible, tell our Plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. For assistance you can call Member Services at the number at the bottom of the page.

Covered services in a medical emergency

Medicare does not provide coverage for emergency medical care outside the United States and its territories.

Our Plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: Worldwide coverage for emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility.

If you need an ambulance to get to the emergency room, our Plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage.*

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our Plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

Urgently needed care in our Plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

You may also access our online directory at **HorizonBlue.com/doctorfinder** to find a participating urgent care center.

Urgently needed care outside our Plan's service area

When you're outside our Plan's service area, you may not be able to get care from a network provider. In that case, our Plan covers urgently needed care you get from any provider.

Our Plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: Worldwide coverage for emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility.

I3. Care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from our Plan.

Visit our website for information on how to get care you need during a declared disaster **medicare.horizonblue.com/disaster-recovery**.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

J. What to do if you are billed directly for services our Plan covers

If a provider sends you a bill instead of sending it to our Plan, you should ask us to pay the bill.

You should not pay the bill yourself. If you do, we may not be able to pay you back.

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do.

J1. What to do if our Plan does not cover services

Our Plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our Plan's Benefits Chart (refer to **Chapter 4** of your *Evidence of Coverage*), **and**
- that you get by following plan rules.

If you get services that our Plan does not cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 of your *Evidence of Coverage* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our Plan. That way, our Plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us or your primary care provider. Providers that give you care as

part of the study do **not** need to be network providers. Please note that this does not include benefits for which our Plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care manager to contact Member Services to let us know you will take part in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that is part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (**www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**). You can also call **1-800-MEDICARE (1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

L. How your health care services are covered in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care that is **not voluntary and is required** under federal, state, or local law.

To be covered by our Plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our Plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
        - You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

You are covered for unlimited inpatient hospital care days, as long as your stay satisfies the Medicare coverage guidelines. Please refer to Chapter 4 for more information.

M. Durable medical equipment (DME)

M1. DME as a member of our Plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our Plan, you usually will **not** own DME, no matter how long you rent it.

Even if you had DME for up to 12 months in a row under Medicare before you joined our Plan, you will **not** own the equipment.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and MA Plans in Chapter 11. You can also find more information about them in the *Medicare & You* 2024 handbook. If you don't have a copy of this booklet, you can get it at the Medicare website **(www.medicare.gov/medicare-and-you)** or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our Plan, **and**
- you leave our Plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our Plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our Plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan.

M3. Oxygen equipment benefits as a member of our Plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our Plan, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our Plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our Plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our Plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services our Plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our Plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage.*

Table of Contents

A. Your covered services

This chapter tells you about services our Plan covers. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Evidence of Coverage*. This chapter also explains limits on some services.

Because you get assistance from NJ FamilyCare, you pay nothing for your covered services as long as you follow our Plan's rules. Refer to **Chapter 3** of your Evidence of Coverage for details about the plan's rules.

If you need help understanding what services are covered, call your care manager and/or Member Services at **1-800-543-5656** (TTY users should call **711**).

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your *Evidence of Coverage* or call Member Services.

C. About our Plan's Benefits Chart

The Benefits Chart tells you the services our Plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and NJ FamilyCare covered services according to the rules set by Medicare and NJ FamilyCare.
- The services (including medical care, behavioral health and substance use disorder treatment services, Managed Long Term Services and Supports (MLTSS), supplies, equipment, and Part B prescription drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care. **Chapter 3** of your Evidence of Coverage has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in bold.
- In addition, the following services not listed in the Benefits Chart require prior authorization:
    - Cognitive Therapy
    - Eyelid Surgery
    - Gastric Bypass/Bariatric Procedures
    - Hyperbaric Oxygen Therapy
    - Hysterectomy
    - Nutritional supplements and foods associated with genetic disorders or inborn errors of metabolism and treatment of weight loss due a medical condition
    - Pain Management Injections
    - Procedures that could be considered cosmetic
    - Religious Non-Medical Health Care Institutions (RNHCI)
    - Sinus and Nasal Surgery
    - Sterilization
    - Surgery for Sleep Apnea (e.g., Uvulopalatopharyngoplasty (UPPP)/uvulopalatoplasty (UPP))

- Temporomandibular Joint (TMJ) and Jaw Surgery
- Gender Affirmation Surgery
- Transplant Services/Organ Transplants (excluding Corneal Transplants)
- Varicose Vein Surgery

Other important things to know about our coverage:

- You are covered by both Medicare and NJ FamilyCare. Medicare covers health care and prescription drugs. NJ FamilyCare covers your cost sharing for Medicare services, including coinsurance, copayments, and deductibles. NJ FamilyCare (Medicaid) also covers services Medicare does not cover, like long-term care, home and community-based services, over-the-counter drugs, comprehensive dental services, hearing aids, and vision.

- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2024 handbook. View it online at **www.medicare.gov** or ask for a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call (**1-877-486-2048**.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.

- If Medicare adds coverage for any new services during 2024, either Medicare or our Plan will cover those services.

- Our Plan covers all of your Medicare and NJ FamilyCare benefits at no cost to you. We have a single, integrated benefit package that includes your Medicare benefits (including Part D prescription drugs) and your NJ FamilyCare benefits along with extra supplemental benefits that ordinary Medicare and NJ FamilyCare don't cover. The Benefits Chart in this section lists all of these benefits for you in one place.

- If you are within our Plan's two-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, Medicaid-only benefits may not be covered by our

Plan. To find out if a benefit is Medicaid-only, and/or to find out if it will be covered, you can call Member Services at the number at the bottom of the page. All of your Medicare services, including Medicare Part D prescription drugs, will continue to be covered at $0 cost-sharing (no copayments, coinsurance, or deductibles) during the period of deemed continued eligibility.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for Members with Certain Chronic Conditions.

If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for special supplemental benefits for the chronically ill.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

In order to qualify as being chronically ill, you must meet the following criteria:

- have been diagnosed with one or more certain chronic conditions,
- have a higher risk to be in the hospital and
- participate in the Horizon Care Management Program.

Certain chronic conditions include:

- Chronic alcohol and other drug dependence ;
- Autoimmune disorders limited to: Polyarteritis nodosa, Polymyalgia rheumatic, Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus;
- Cancer, excluding pre-cancer conditions or in-situ status;
- Cardiovascular disorders limited to: Cardiac arrhythmias, Coronary artery disease, and Peripheral vascular disease, and Chronic venous thromboembolic disorder;
- Chronic heart failure;
- Dementia;
- Diabetes mellitus;
- End-stage liver disease;
- End-stage renal disease requiring dialysis;
- Severe hematologic disorders limited to; Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodyspalalatic syndrome, Sickle cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder;

- HIV/AIDS;
- Chronic lung disorders limited to; Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis and Pulmonary hypertension;
- Chronic and disabling mental health conditions limited to: Bipolar disorder, Major depressive disorder, Paranoid disorder, Schizophrenia, and Schizoaffective disorder;
- Neurologic disorders limited to; Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (ex. Hemiplegia, paraplegia, monoplegia), Huntington's disease, Multiple sclerosis, Parkinson's disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit;
- Stroke;
- Prediabetes;
- Chronic Obstructive Pulmonary disease;
- Hypertension;
- Chronic Anemia; and
- Chronic Kidney Disease

Please go to the "Special Supplemental Benefits for the Chronically Ill" row in the Medical Benefits Chart for further detail.

Contact us to find out exactly which benefits you may be eligible for.

All preventive services are free. You will find this apple 🍎 next to preventive services in the Benefits Chart.

D. Our Plan's Benefits Chart

Services that our Plan pays for		
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	
	Acupuncture We pay for acupuncture visits if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. Acupuncture treatments must be stopped if you don't get better or if you get worse.	Coverage limited to acupuncture provided by a licensed physician (MD or DO).

Services that our Plan pays for		
	**Alcohol misuse screening and counseling** We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	
	Ambulance services Covered ambulance services include ground and air (airplane and helicopter), and ambulance services The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	Emergency transportation is covered worldwide when you are temporarily outside of the United States and its territories. The annual maximum is limited to $60,000. **Except in an emergency, prior authorization must be obtained by your network provider from Horizon NJ TotalCare for air, ground and non-emergency services.**

Services that our Plan pays for		
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.
	Autism Spectrum Disorder Services For all members with an Autism Spectrum Disorder (ASD) diagnosis, we pay for: • Applied Behavioral Analysis (ABA) • augmentative and alternative communication services and devices • Sensory Integration (SI) services • allied health services (physical therapy, occupational therapy and speech therapy) • Developmental, Individual-differences, and Relationship-based (DIR) services, including but not limited to DIR Floortime and the Greenspan approach therapy	Contact the Horizon behavioral health program at **1-800-543-5656**, between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**.

Services that our Plan pays for		
	Blood and Blood Products Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage begins with the first pint of blood. Coverage is unlimited (no limit on volume or number of blood products). Covered for services rendered beyond Medicare Part A & B limits.	
	**Bone mass measurement** We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	
	**Breast cancer screening (mammograms)** We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and over • clinical breast exams once every 12 months • Additional screenings are available if medically necessary.	

Services that our Plan pays for		
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	
	**Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)** We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use (if appropriate), • check your blood pressure, **and/or** • give you tips to make sure you are eating well.	
	**Cardiovascular (heart) disease testing** We pay for blood tests to check for cardiovascular disease annually for all members 20 years of age or older, and more frequently if medically necessary. These blood tests also check for defects due to high risk of heart disease.	

Services that our Plan pays for		
	Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 12 months • Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. • Human Papillomavirus (HPV) testing once every five years for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test • All laboratory costs associated with the listed tests are covered. • Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment • clinical laboratory services • certain medical supplies • durable medical equipment • prefabricated orthoses • physical therapy services • diagnostic radiological services when they are prescribed by a chiropractor within their scope of practice	**Prior Authorization must be obtained by your network provider for adjustments of the spine to correct alignment.**

Services that our Plan pays for		
	Clinical Trials Coverage for medical problems/complications and for routine patient costs. However, the plan is not required to pay for the costs of items and services that are reasonably expected to be paid for by the sponsors of a Medicare and/or NJ FamilyCare approved clinical trial.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for all clinical trial services.**
	Colorectal cancer screening We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	

Services that our Plan pays for		
	Colorectal cancer screening (continued) • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result.	

Services that our Plan pays for		
	Dental services This benefit includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. We pay for dental examinations, cleanings, fluoride treatment and any necessary x-rays. We pay for this service twice per rolling year. Examples of covered services include (but are not limited to): • oral evaluations (examinations) • x-rays and other diagnostic imaging • dental cleaning (prophylaxis) • topical fluoride treatments • fillings • crowns • root canal therapy • scaling and root planing • complete and partial dentures • oral surgical procedures (to include extractions) • intravenous anesthesia/sedation (where medically necessary for oral surgical procedures) **This benefit is continued on the next page**	**Some services may require a prior authorization**. Ask your dentist to explain. Dental care for cosmetic reasons is not covered.

Services that our Plan pays for		
	Dental services (continued) Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Some procedures may require prior authorization with documentation of medical necessity, including: • Orthodontic services for members up to age 21 with adequate documentation of a handicapping malocclusion or medical necessity. • Dental treatment in an operating room or ambulatory surgical center. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	
	Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	

Services that our Plan pays for		
	Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. For those with diabetes, yearly exams for diabetic retinopathy are also covered.	
	Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: • a blood glucose monitor • blood glucose test strips • lancet devices and lancets • glucose-control solutions for checking the accuracy of test strips and monitors **This benefit is continued on the next page**	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for diabetic supplies/services over $250 and orthotics costing over $500.**

Services that our Plan pays for		
	Diabetic self-management training, services, and supplies (continued) • For people with diabetes who have severe diabetic foot disease, we pay for the following: • one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** • one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. • Insulin, syringes, injection aids, insulin pumps, insulin infusion devices, and oral agents for blood sugar control are also covered. Diabetic test strips (blood glucose test strips) are limited to two specified manufacturers, Ascensia (Contour) and LifeScan (OneTouch) products when obtained at the pharmacy. If you obtain the diabetic test strips through one of our Durable Medical Equipment (DME) suppliers, the limitation will not apply. There is a limit of 204 test strips covered every 30 days when obtained at the pharmacy. • Therapeutic continuous glucose monitors (CGMs) are limited to, Dexcom (G5 and G6) and Freestyle Libre when obtained at the pharmacy. There are no limits at the pharmacy for non-therapeutic continuous glucose monitors **This benefit is continued on the next page**	

Services that our Plan pays for		
	Diabetic self-management training, services, and supplies (continued) • Continuous Glucose Monitoring (CGM) preferred products are Dexcom CG6 and Abbott Freestyle Libre.	
	Diabetes Testing and Monitoring Covers yearly eye exams for diabetic retinopathy and foot exams every six months for Members with diabetic peripheral neuropathy and loss of protective sensations. Covered beyond Medicare Part B limits.	
	Diagnostic and Therapeutic Radiology and Laboratory Services Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays. Covered for services rendered beyond Medicare Part A & B limits. Diagnostic Radiological Services (e.g., CT, MRI, etc.) - Your provider must obtain prior authorization from Horizon NJ TotalCare or its designee for certain diagnostic radiological services such as MRI, Nuclear Medicine, and PET/CT. Therapeutic Radiological Services - Your provider must obtain prior authorization from Horizon NJ TotalCare or its designee.	
	Doula Services We pay for the services of a doula. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula does not replace a licensed medical professional, and cannot perform clinical tasks.	

Services that our Plan pays for		
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of your *Evidence of Coverage* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizer • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **HorizonBlue.com/doctorfinder**. **This benefit is continued on the next page**	**Prior authorization from Horizon NJ TotalCare is required for DME items over $250. All rental items also require prior authorization. DME rentals require authorization except hospital grade breast pumps.**

Services that our Plan pays for		
	Durable medical equipment (DME) and related supplies (continued) Specialty medical foods, assistive technology devices, incontinence supplies and wigs are covered for certain medical conditions. Generally, our Plan covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to our Plan and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).)	
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) For members under 21 years of age, we pay for the following services: • well child care • preventive screenings **This benefit is continued on the next page**	

Services that our Plan pays for		
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) (continued) • medical examinations • vision and hearing screenings and services • immunizations • lead screening • private duty nursing services We pay for private duty nursing for eligible EPSDT members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. Coverage may extend beyond Medicare coverage limits for analogous services.	
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part. **This benefit is continued on the next page**	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered.

Services that our Plan pays for		
	Emergency care (continued) • In the case of a pregnant woman in active labor, when: o There is not enough time to safely transfer you to another hospital before delivery. o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.	Coverage is provided when you are temporarily outside of the United States and its territories. The annual maximum is limited to $60,000.
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions **This benefit is continued on the next page**	

Services that our Plan pays for		
	Family planning services (continued) • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling Horizon covers this benefit when performed by a participating provider. The State pays directly for this care through NJ FamilyCare Fee-for-Service when these services are performed by a non-participating or an out-of-network provider. We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing Services furnished by out-of-network providers are paid for directly by NJ FamilyCare. **<u>Exceptions</u>: Services primarily related to the diagnosis and treatment of infertility are not covered.**	
	Federally Qualified Health Centers (FQHC) Covers outpatient and primary care services from community-based organizations. Covered for services rendered beyond Medicare Part B limits.	

Services that our Plan pays for		
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We pay for the following services: • routine hearing exams • diagnostic hearing exams and balance exams • otologic and hearing aid examinations prior to prescribing hearing aids • hearing aids, as well as associated accessories and supplies • exams for the purpose of fitting hearing aids • follow-up exams and adjustments • repairs after warranty expiration	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for hearing aid services.**
	Hepatitis C Virus (HCV) Screening in Adults Covered services include: • Screening test for adults at high risk for Hepatitis C Virus infection. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test. • Single screening test is covered for adults who are not high risk, but who were born from 1945 through 1965. • Screening test covered for those who had a blood transfusion before 1992. Services eligible only when ordered by the member's Primary Care Provider.	

Services that our Plan pays for		
	**HIV screening** We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.	
	Home-delivered Meals After an inpatient discharge to your home, you may be eligible to receive up to 34 nutritious meals over a 17-day period to help you recover from your illness. Home-delivered meals are limited to two occurrences per calendar year. Covers delivery of nutritiously balanced meals specifically for you. Meals must be coordinated by your Care Manager and may be offered following your acute inpatient hospital stay or inpatient surgery only if the meals are: 1. Needed due to an illness and 2. Consistent with established medical treatment of the illness. Meal delivery will arrive within 1 to 3 business days after the order is made to our meal vendor.	

Services that our Plan pays for		
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies • Coverage includes nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment, and appliances suitable for use in the home; audiology services; physical therapy; speech-language pathology; and occupational therapy. • Home Health Agency Services must be provided by a home health agency that is licensed through the Department of Health as a home health agency and meets Medicare participation requirements.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for all home health services and supplies.**

Services that our Plan pays for		
	Home infusion therapy Our Plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our Plan covers home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	**Your provider must obtain prior authorization from Horizon NJ TotalCare or its designee.**
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our Plan must help you find Medicare-certified hospice programs in the plan's service area. **This benefit is continued on the next page**	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our Plan.

Services that our Plan pays for		
	Hospice care (continued) Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care The plan also covers certain durable medical equipment, as well as spiritual and grief counseling. For members under 21 years of age, both palliative and curative care are covered. **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to **Section F** of this chapter for more information. **For services covered by our Plan but not covered by Medicare Part A or Medicare Part B:** • Our Plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our Plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our Plan at the same time. For more information, refer to **Chapter 5** of your Evidence of Coverage. **Note:** If you need non-hospice care, call your care manager and/or Member Services to arrange the services. Non-hospice care is care that is **not** related to your terminal **This benefit is continued on the next page**	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for all hospice care services.**

Services that our Plan pays for		
	Hospice care (continued) prognosis. Our Plan covers all of your medical care not related to your terminal prognosis as it normally would.	
	Immunizations We pay for the following services: • pneumonia vaccine • flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your *Evidence of Coverage* to learn more. The full childhood immunization schedule is covered for members under the age of 21.	
	Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: **This benefit is continued on the next page**	

Services that our Plan pays for		
	Inpatient hospital care (continued) • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse disorder treatment services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our Plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. **This benefit is continued on the next page**	

Services that our Plan pays for		
	Inpatient hospital care (continued) • blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are you a Hosptial Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. We pay for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. The plan covers the following services: • inpatient services in a psychiatric hospital • services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital **This benefit is continued on the next page**	Contact the Horizon behavioral health program at **1-800-543-5656,** between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**.

Services that our Plan pays for		
	Inpatient services in a psychiatric hospital (continued) • Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting)	**Except in an emergency, prior authorization must be obtained by your network provider from the Horizon behavioral health program.**

Services that our Plan pays for		
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.	

Services that our Plan pays for		
	Lung cancer screening with low dose computed tomography (LDCT) Our Plan pays for lung cancer screening for qualified individuals every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. After the first LDCT lung cancer screening, our Plan pays for another screening each year with a written order from your doctor or other qualified provider. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	

Services that our Plan pays for		
	Managed Long Term Services and Supports (MLTSS) The MLTSS program provides Home- and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. This MLTSS program is available to members who meet certain clinical and financial requirements. MLTSS services include (but are not limited to): • assisted living services • cognitive, speech, occupational, and physical therapy • chore services • home-delivered meals • residential modifications (such as the installation of ramps or grab bars) • vehicle modifications • social adult day care • non-medical transportation	Ask your Care Manager for more information.
	Medical Day Care This benefit is for people with physical and/or cognitive impairments. Our Plan pays for preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for all Medical Day Care services.**

Services that our Plan pays for		
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare (this includes our Plan, any other Medicare Advantage plan, or Original Medicare). We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	
	Medical Supplies Examples of covered items include wound care, suction, tape, gloves, and wound dressing. Covered for services rendered beyond Medicare Part B limits for approved procedures and services.	
	Medicare Diabetes Prevention Program (MDPP) Our Plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	

Services that our Plan pays for		
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our Plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our Plan authorized • clotting factors you give yourself by injection if you have hemophilia • immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • antigens • certain oral anti-cancer drugs and anti-nausea drugs **This benefit is continued on the next page**	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for certain injectable and specialty pharmaceuticals, including but not limited to Flolan and derivatives, and Xolair.** **Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for certain injectable medications; such as those used to treat rare disease, multiple sclerosis, rheumatoid arthritis, psoriatic arthritis, psoriasis, cancer, anemia, Crohn's disease, and ulcerative colitis.**

Services that our Plan pays for		
	Medicare Part B prescription drugs (continued) • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit. **Chapter 5** *of your Evidence of Coverage* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** *of your Evidence of Coverage* gives more information about the *Explanation of Benefits (*EOB) and how it helps you track your drug coverage. Certain Part B drugs may be subject to step therapy requirements. For more information about step therapy, see Chapter 5, Section C3 of this document. You may also call Member Services to find out which Part B drugs have these requirements (phone numbers are printed at the bottom of the page.)	

Services that our Plan pays for		
	Non-Physician Services Covered for services rendered beyond Medicare Part B limits (within the scope of practice and in accordance with state certification/licensure requirements, standards and practices) by certified nurse midwives, certified nurse practitioners, clinical nurse specialists, physician assistants, social workers, physical therapists, and psychologists.	
	Nurse Line • A confidential service that enables you to speak with a registered nurse, toll free 24 hours a day to assist with health-related questions and concerns.	Please call **1-800-711-5952** to contact the 24/7 Nurse Line.
	Nurse Midwife Services Nurse midwife services are covered.	
	Nursing facility care A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy **This benefit is continued on the next page**	

Services that our Plan pays for		
	Nursing facility care (continued) • respiratory therapy • drugs given to you as part of your Plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our Plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	

Services that our Plan pays for		
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	
	Opioid treatment program (OTP) services Our Plan pays for the following services to treat opioid use disorder (OUD): through an Opioid Treatment Program (OTP): • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	Contact the Horizon behavioral health program at **1-800-543-5656**, between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**.

Services that our Plan pays for		
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • other outpatient diagnostic tests	**Your provider must obtain prior authorization from Horizon NJ TotalCare or its designee for some in-network services such as: CT Scans, MRIs, PET Scans, MUGA Scans, Virtual Colonoscopies, Angiography, Non-OB Ultrasound, Stress Echocardiography, Echocardiography, Cardiac Computed Tomography Angiography (CCTA), Cardiac Catheterization, Cardiac Implantable Devices including Implantable Cardioverter Defibrillator (ICD), Pacemaker, Radiation Therapy Management and Nuclear Cardiology tests.**

Services that our Plan pays for		
	Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: **This benefit is continued on the next page**	**Your provider must obtain prior authorization from Horizon NJ TotalCare or its designee for services such as diagnostic radiological services, mental**

Services that our Plan pays for		

	Outpatient hospital services (continued)
	• services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
	  ○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient."
	  ○ Sometimes you can be in the hospital overnight and still be "outpatient."
	  ○ You can get more information about being inpatient or outpatient in this fact sheet: **www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf**.
	• labs and diagnostic tests billed by the hospital
	• mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it
	• X-rays and other radiology services billed by the hospital
	• medical supplies, such as splints and casts
	• preventive screenings and services listed throughout the Benefits Chart
	• some drugs that you can't give yourself
	Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.
	This benefit is continued on the next page
		health care, and durable medical equipment.

Services that our Plan pays for		
	Outpatient hospital services (continued) You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling **1-800- MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that our Plan pays for		
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws • an Independent Practitioner Network or IPN (psychiatrist, psychologist, or Advanced Practice Nurse (APN)) Additionally, the plan covers the following services: • adult mental health rehabilitation (supervised group homes and apartments) • mental health outpatient (clinic/hospital services) • partial care and medication management	Contact the Horizon behavioral health program at **1-800-543-5656,** between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**. **Prior authorization requirements may apply.**

Services that our Plan pays for		
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech language therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for all therapy services and additional visits.**
	Outpatient substance use disorder treatment services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment The plan covers substance use disorder screening, referrals, prescription drugs, and treatment of conditions. Covered services include, but are not limited to, the following: • non-medical detoxification/non-hospital based withdrawal management **This benefit is continued on the next page**	Contact the Horizon behavioral health program at **1-800-543-5656,** between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**. **Except in an emergency, prior authorization must be obtained by your network provider from the Horizon behavioral health program.**

Services that our Plan pays for		
	Outpatient substance use disorder treatment services (continued) • substance use disorder short term residential • ambulatory withdrawal management with extended on-site monitoring/ambulatory detoxification • substance use disorder partial care • substance use disorder intensive outpatient • substance use disorder outpatient • opioid treatment services (methadone and non-methadone medication assisted treatment) o Refer to "Opioid treatment program (OTP) services" earlier in this chart for details. • Peer Recovery Support Services (PRSS)	
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note**: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	**For certain surgical procedures prior authorization must be obtained by your network provider from Horizon NJ TotalCare. Please refer to Section C of this Chapter for a list of services requiring prior authorization.**

Services that our Plan pays for		
	Over-the-Counter (OTC) Extra Benefits Card Use your Horizon EXTRA Benefits Card to access the following: Every three (3) months (quarterly) you will receive a combined credit of $720 (up to $2,880 yearly) that will allow you to purchase over the counter retail and catalog items without a prescription from participating providers. Includes over 900,000 eligible items like lumbar cushions, toothbrushes, diabetic socks, thermometers, hot/cold packs and more. How to use your Horizon EXTRA Benefits Card: • Take your card to a participating retailer to make an eligible purchase. • For a list of participating retailers, visit **HorizonExtraBenefits.com** • Download the free *myTotal Benefits* mobile app to check your card balance, find a participating retailer and scan items to check for eligibility. • Place a catalog order using the plan's approved vendor via phone or mail. Orders can also be placed at **HorizonExtraBenefits.com**. All orders will be delivered through the mail. Members can call to place an order directly at **1-800-480-6598** The quarterly credit will not carry over from quarter to quarter or from year to year. All purchases must be placed using the Horizon EXTRA Benefits Card and participating retailers like Walmart, CVS, Dollar General and Walgreens. Please see the Special Supplemental Benefits for the Chronically Ill (SSBCI) section in the benefit chart for possible additional benefits.	

Services that our Plan pays for		
	Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	Contact the Horizon behavioral health program at **1-800-543-5656,** between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY users should call **711**. **Except in an emergency, if partial hospitalization involves mental health care or substance abuse disorder treatment, prior authorization must be obtained by your network provider from the Horizon behavioral health program.**

Services that our Plan pays for		
	Personal Care Assistance (PCA) Covers health related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for personal care assistant services.**
	Physician/provider services, including doctor's office visits We pay for the following services: o medically necessary health care or surgery services given in places such as: o physician's office o certified ambulatory surgical center o hospital outpatient department o consultation, diagnosis, and treatment by a specialist o basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment o Certain telehealth services, including: urgently needed services and behavioral health services (therapy and psychiatry), as well as consultations, exams, and diagnosis that can be performed effectively via telehealth. **This benefit is continued on the next page**	**For certain surgical procedures prior authorization must be obtained by your network provider. Please refer to Section C of this Chapter for a list of services requiring prior authorization.**

Services that our Plan pays for		
	Physician/provider services, including doctor's office visits(continued) ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ○ You can access these services by seeing a licensed, board-certified CareOnline network provider, 24 hours a day, seven days a week, using a web-enabled computer or mobile device (only Behavioral Health Therapy Visits are available via mobile app). No appointment needed for urgent telemedicine visits and an ePrescription can be provided if you need one. Scheduled appointments are needed for behavioral health visits, which are available 7am-11pm, 7 days a week. ○ To access these telehealth services, you must first register and create an account by either calling **1-877-716-5657** or downloading the Amwell: Doctor Visits 24/7 app. Registration through the customer support line is separate from the mobile app. The same email and password created for setup can be used to create both accounts; however, the information isn't shared. To register for the mobile app, click Sign Up and follow the below instructions. • Fill in your full name, DOB, Gender, State and Email Address. • Create a password and agree to the Terms of Use. • Enter Service Key: HORIZON **This benefit is continued on the next page**	

Services that our Plan pays for		
	Physician/provider services, including doctor's office visits (continued) • Select Horizon NJ TotalCare (HMO D-SNP) from the Insurance drop down • Enter Subscriber ID • Are you the primary subscriber? Select Yes or No • Select Continue • Insurance will be validated and registration will be complete • To begin a virtual visit, you must go to **HorizonCareOnline.com** and sign in. • To begin a virtual Behavioral Health Therapy visit using your mobile device. • Open Amwell: Doctor Visits 24/7 app from Apple / Google Play store from your mobile device • Allow "Amwell" to use your location? Select "Allow While Using App" • Sign in. We encourage you to set up your account before you need it so it's ready to go when you have a need for a virtual visit. If you need technical assistance, please call **1-877-716-5657** (TTY **711**) or send an email to **HorizonCareOnline@AmericanWell.com**. You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Our telehealth service allows its network doctors to ePrescribe in New Jersey through only video visits. Telehealth services are available in all states, although ePrescribing services may be restricted by state laws **This benefit is continued on the next page**	

Services that our Plan pays for		
	Physician/provider services, including doctor's office visits (continued) **Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare.** • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of your location • telehealth services for diagnosis, evaluation, and treatment of mental health disorders • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes • evaluation of video and/or images you send to your doctor, interpretation, and follow-up by your doctor within 24 hours • consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • second opinion by another network provider before surgery **This benefit is continued on the next page**	

Services that our Plan pays for		
	Physician/provider services, including doctor's office visits (continued) • Non-routine dental care. Covered services are limited to: o surgery of the jaw or related structures o setting fractures of the jaw or facial bones o pulling teeth before radiation treatments of neoplastic cancer o services that would be covered when provided by a physician	
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • routine exams • Therapeutic shoes or inserts for those with severe diabetic foot disease and exams to fit those shoes or inserts.	

Services that our Plan pays for		
	Prescription Drugs *(including Medicare Part B and Part D)* Includes prescription drugs (legend and non-legend covered by the NJ FamilyCare program including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals including potassium, and niacin. All blood clotting factors shall be included in the list of blood clotting factors. Horizon will continue to cover physician administered drugs for all enrollees. Covered for services rendered beyond Medicare Part B and Part D benefit limits. (See the Medicare Part B prescription drugs benefit for more information for Part B drugs.) Also includes other over the counter (OTC) items such as aspirin, cough and allergy medications which would require a prescription from your provider (a doctor or other prescriber).	
	Private Duty Nursing (PDN) This benefit is for eligible beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. It is covered for MLTSS members of any age.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for all private duty nursing services under age 21.**
	**Prostate cancer screening exams** For men age 50 and over, (and for men 40 and older with a family history of prostate cancer or other risk factors), we pay for the following services once every 12 months: • a digital rectal exam a prostate specific antigen (PSA) test	

Services that our Plan pays for		
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare for prosthetics costing over $250 and foot orthotics costing over $500.**
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare.**
	Routine Annual Physical Exams Covered for services rendered beyond Medicare Part B benefit limits.	

Services that our Plan pays for		
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	
	Silver&Fit® Healthy Aging and Exercise Program As a Silver&Fit member, you have the following options available at no cost to you: Fitness Center Membership: You can visit a participating fitness center or YMCA* near you that takes part in the program. Many participating fitness centers or YMCAs may also offer low-impact classes focused on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion, balance, agility, and coordination. • Workout Plans: By answering a few online questions about your areas of interest, you will receive a customized workout plan, including instructions on how to get started and suggested digital workout videos. **This benefit is continued on the next page**	

Services that our Plan pays for		
	Silver&Fit® Healthy Aging and Exercise Program (continued) • Home Fitness Kits: You are eligible to receive one Home Fitness Kit per benefit year from a variety of fitness categories. • Healthy Aging classes (online) • Daily workout classes on Facebook Live and YouTube • Signature Series workout videos for all fitness levels on **www.SilverandFit.com** • Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. • A quarterly newsletter • Rewards: Earn a hat and pins for reaching new activity milestones. • Access to telephonic Healthy Aging Coaching You can register online at **Silver&Fit.com** or call our Member Services at **1-877-427-4788 (**TTY **711**), Monday – Friday, 8:00 a.m. – 9:00 p.m., ET. The Silver&Fit program has **Something for Everyone®!** ***Non-standard membership services that call for an added fee are not part of the Silver&Fit program and will not be reimbursed.** **This benefit is continued on the next page**	

Services that our Plan pays for		
	Silver&Fit® Healthy Aging and Exercise Program (continued) **ASH Fitness has no affiliations, interest, endorsements, or sponsorships with any of the organizations or clubs. Some clubs may require a fee to join. Such fees are not part of the Silver&Fit programs and will not be reimbursed by ASH Fitness. **The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, Silver&Fit Connected!, and Something for Everyone are trademarks of ASH. Limitations, and restrictions may apply. Participating facilities and fitness chains may vary by location and are subject to change. Kits and rewards are subject to change.**	
	Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 11 of this document. Skilled nursing facilities are sometimes called "SNFs.") We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy **This benefit is continued on the next page**	**Prior authorization must be obtained by your network provider from Horizon NJ TotalCare.**

Services that our Plan pays for		
	Skilled nursing facility (SNF) care (continued) • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • medical and surgical supplies given by skilled nursing facilities • lab tests given by skilled nursing facilities • X-rays and other radiology services given by skilled nursing facilities • appliances, such as wheelchairs, usually given by skilled nursing facilities • physician/provider services • long term (custodial) care in a nursing facility You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our Plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides skilled nursing facility care) • a skilled nursing facility where your spouse or domestic partner lives at the time you leave the hospital • Long-term (custodial) care in a Nursing Facility is covered for those who meet Nursing Facility level of care criteria.	

Services that our Plan pays for		
	Smoking and tobacco use cessation If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. The plan also covers over-the-counter (OTC) smoking cessation products, including nicotine gums, nicotine lozenges and nicotine patches. These are also covered without a prescription using your Horizon Extra Benefits Card.	
	Special Supplemental Benefits for the Chronically Ill (SSBCI) For those members that qualify for SSBCI, your benefits will be enhanced. Every three (3) months (quarterly) you will receive an additional $160 (up to $640 yearly) allowance on the EXTRA Benefits Card that can be used towards: • OTC retail and catalog approved items • Healthy Food (tobacco and alcohol are not permitted) • Household utilities such as electric, gas* and water bills **This benefit is continued on the next page**	Please reach out to your Care Manager or call Member Services to get connected with your Care Manager if you have questions.

Services that our Plan pays for		
	Special Supplemental Benefits for the Chronically Ill (SSBCI) (Continued) Total overall benefit allowance of **$880 per quarter/$3520 annually** for OTC, retail, Catalog, Grocery, and Utilities. Funds consolidated into one purse administered through **Horizon EXTRA Benefits card.** *Gasoline is not included You will be able to use these new enhanced benefits within 72 hours of determined eligibility. In order to qualify as being chronically ill, you must meet the following criteria: • Have been diagnosed with one or more certain chronic conditions, • Have a higher risk to be in the hospital and • Participate in the Horizon Care Management Program. Certain chronic conditions include: • Chronic alcohol and other drug dependence • Autoimmune disorders limited to: Polyarteritis nodosa, Polymyalgia rheumatic, Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus; • Cancer, excluding pre-cancer conditions or in-situ status; • Cardiovascular disorders limited to: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, and Chronic venous thromboembolic disorder; • Chronic heart failure; • Dementia; • Diabetes mellitus; • End-stage liver disease; • End-stage renal disease requiring dialysis; **This benefit is continued on the next page**	

Services that our Plan pays for		
	Special Supplemental Benefits for the Chronically Ill (SSBCI) (**Continued**) • Severe hematologic disorders limited to; Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodyspalalatic syndrome, Sickle cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder; • HIV/AIDS; • Chronic lung disorders limited to; Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis and Pulmonary hypertension; • Chronic and disabling mental health conditions limited to: Bipolar disorder, Major depressive disorder, Paranoid disorder, Schizophrenia, and Schizoaffective disorder; • Neurologic disorders limited to; Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (ex. Hemiplegia, paraplegia, monoplegia), Huntington's disease, Multiple sclerosis, Parkinson's disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit; and • Stroke; • Prediabetes; • Chronic Obstructive Pulmonary disease; • Hypertension; • Chronic Anemia; and • Chronic Kidney Disease	

Services that our Plan pays for		
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our Plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	

Services that our Plan pays for		
	Transportation Medicaid Fee-for-Service directly covers non-emergency transportation. Covered services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). All non-emergency transportation is arranged through the state's transportation vendor, Modivcare. To schedule transportation, call Modivcare at **1-866-527-9933**. You can also ask your PCP or Care Manager to help you to arrange this service. Please call your care manager and/or Member Services at **1-800-543-5656.** • Transportation must be arranged by 12 noon at least two (2) business days in advance of transportation need by calling **1-866-527-9933** unless the physician indicates the appointment is urgent. • Transportation beyond the limits of Medicare Part B coverage.	

Services that our Plan pays for		
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).	Coverage is provided worldwide when you are temporarily outside of the United States and its territories. The annual maximum is limited to $60,000.

Services that our Plan pays for		
	Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye, including a comprehensive eye exam once per year for all members. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans *who are age* 50 and over • Hispanic Americans *who are* 65 or over For all other members age 35 or older, a glaucoma screening is covered every five years. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. **This benefit is continued on the next page**	

Services that our Plan pays for		
	Vision care (continued) The plan also covers the following: • Optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. • Optometrist services and optical appliances must be obtained at a participating Davis Vision Provider. • replacement lenses and frames (or contact lenses) ○ once every 24 months for beneficiaries age 19 through 59, **or** ○ once per year for beneficiaries 18 years of age or younger, **or** once per year for beneficiaries 60 years of age or older	
	**"Welcome to Medicare" preventive visit** We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	

E. Benefits covered outside of our Plan

We don't cover the following services, but they are available through Medicare or NJ FamilyCare.

- Non-emergency transportation, including mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and delivery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). These services are paid for directly by Medicaid (also known as Medicaid Fee-for-Service).

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by our Plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our Plan at the same time. For more information, refer to **Chapter 5** of your *Evidence of Coverage.*

Note: If you need non-hospice care, call your care manager to arrange the services. Non-hospice care is care not related to your terminal prognosis.

F. Benefits not covered by our Plan, Medicare, or NJ FamilyCare

This section tells you about benefits excluded by our Plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** *of your Evidence of Coverage.*

In addition to any exclusions or limitations described in the Benefits Chart, our Plan does not cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and NJ FamilyCare standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary

- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines, and as described in Chiropractic Services in the Benefits Chart in **Section D**
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomyand LASIK surgery
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities

Chapter 5: Getting your outpatient prescription drugs

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and NJ FamilyCare. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage.*

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to **Chapter 5**, **Section F** "If you are in a Medicare-certified hospice program."

Rules for our Plan's outpatient drug coverage

The Drug List tells you how to find out about your NJ FamilyCare drug coverage.

We usually cover your drugs as long as you follow the rules in this section.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription.

Your prescribed drug must be on our Plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9 Section G2** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug.

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our Plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website at **HorizonBlue.com/ma-pharmacy-search** or contact Member Services.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered prescription drug.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Evidence of Coverage*.
- If you need help getting a prescription filled, contact Member Services.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our Plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
    - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our Plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

Our Plan's mail-order service allows you to order up to a 90-day supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, contact one of the following mail-order services:

AllianceRx Walgreens Pharmacy **1-800-391-1916** (TTY users: **711**) 24 hours a day, 7 days a week **www.alliancerxwp.com**	Pillpack by Amazon Pharmacy **1-855-494-4897** (TTY users: **711**) 24 hours a day, 7 days a week **www.pillpack.com/horizonblue**	Express Scripts® Pharmacy **1-833-715-0960** (TTY users: **711**) 24 hours a day, 7 days a week **www.express-scripts.com/rx**

Usually, a mail-order prescription arrives within 14 days. However, sometimes your mail-order may be delayed. If this happens, our Plan allows for a mail delay override. Please call Member Services to get an override approval. Once approval is received, we can transfer your prescription to the pharmacy of your choice or have your prescriber telephone a shorter supply to the pharmacy.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. New prescriptions the pharmacy gets from your provider's office

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by phone or mail.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our Plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

A8. Using a pharmacy not in our Plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our Plan.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you are traveling in the United States and territories and become ill, lose or run out of your prescription.
- If you were unable to get a covered drug in a timely manner because, for example, there was not a network pharmacy nearby that provided 24/7 service.
- If you were trying to fill a covered drug not regularly stocked at a network retail or mail order pharmacy.
- If you were evacuated or displaced due to a federally-declared disaster or other public health emergency declaration and could not get your drug at a network pharmacy.
- If you were provided a covered drug while in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting and could not get your drug filled at a network pharmacy.
- We will cover your drug for a temporary 30-day supply of medication, or for fewer days, based on your prescription, for the circumstances above.

In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of your *Evidence of Coverage*.

B. Our Plan's Drug List

We have a *List of Covered Drugs.* We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our Plan's Drug List when you follow the rules we explain in this chapter.

If we cover a drug only for some medical conditions, we clearly identify it on our Drug List and in Medicare Plan Finder along with the specific medical conditions covered.

B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under NJ FamilyCare.

Our Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Generally, generic drugs work just as well as brand name drugs and usually cost less. There are generic drug substitutes available for many brand name drugs. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our Plan also covers certain over-the-counter drugs (OTC) drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit our Plan's website at **MyPrime.com**. The Drug List on our website is always the most current one.
- Call Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.

- Use our "Real Time Benefit Tool" at MyPrime.com or call Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

Our Plan does not pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Evidence of Coverage* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our Plan's outpatient drug coverage (which includes Medicare Part D and NJ FamilyCare drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our Plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.

2. Our Plan cannot cover a drug purchased outside the United States and its territories.

3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our Plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or NJ FamilyCare cannot cover the types of drugs listed below.

- drugs used to promote fertility
- drugs used for the relief of cough or cold symptoms
- drugs used for cosmetic purposes or to promote hair growth
- prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

- drugs used for the treatment of sexual or erectile dysfunction
- drugs used for the treatment of anorexia, weight loss or weight gain
- outpatient drugs made by a company that says you must have tests or services done only by them

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our Plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Evidence of Coverage.*

1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. In most cases, if there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug won't work for you **or** wrote "No substitutions" on your prescription for a brand name drug **or** told us the medical reason that the generic drug or other covered drugs that treat the same condition will work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our Plan before you fill your prescription. If you don't get approval, we may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at **MyPrime.com**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of the *Evidence of Coverage.*

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our Plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our Plan covers the drug, but there are special rules or limits on coverage. As explained in the section above **(C. Limits on some drugs),** some drugs our Plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
    - is no longer on our Drug List **or**
    - was never on our Drug List **or**
    - is now limited in some way.
2. You must be in one of these situations:
    - You were in our Plan last year.
        - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of a 30-day supply of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
    - You are new to our Plan.
        - We cover a temporary supply of your drug during the first **90** days of your membership in our Plan.
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
    - You have been in our Plan for more than 90 days, live in a long-term care facility, and need a supply right away.

- We cover one 31- day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
- During a level of care change, drugs may be prescribed that are not covered by our Plan. If this happens, you and your doctor must use our Plan's coverage determination request process.
- To prevent a gap in care when you are discharged, you may get a full outpatient supply that will allow therapy to continue once the limited discharge supply is gone. This outpatient supply is available before discharge from a Medicare Part A stay.
- When you are admitted to or discharged from an "LTC" Long Term Care setting, you may not have access to the drugs you were previously given. However, you may get a refill upon admission or discharge. An override of the "refill too soon" message is provided for each medication which would be impacted by you being admitted to or discharged from an LTC facility. Early refill messages are not used to limit appropriate and necessary access to your Part D benefit, so you are allowed to access a refill upon admission or discharge.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our Plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Evidence of Coverage*.

If you need help asking for an exception, contact Member Services.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at MyPrime.com **or**

- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we send you information about the specific change we made once it happens.

  - You or your provider can ask for an "exception" from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Evidence of Coverage* for more information on exceptions.

- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

- We add a generic drug that is not new to the market and

  - Replace a brand name drug currently on our Drug List **or**

  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**

- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Evidence of Coverage*.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change does not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our Plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our Plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our Plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our Plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our Plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our Plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our Plan covers. Refer to **Chapter 4** of your *Evidence of Coverage* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our Plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications

- any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services.

G3. Drug management program for safe use of opioid medications

Our Plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from certain pharmacies and/or from certain doctors
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Evidence of Coverage*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and NJ FamilyCare Medicaid prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid**.**

Because you are eligible for NJ FamilyCare, you get "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
    - We call this the "Drug List." It tells you:
        - Which drugs we pay for
        - If there are any limits on the drugs
    - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at **HorizonBlue.com/ma-drug-search**.
- **Chapter 5** of your *Evidence of Coverage*.
    - It tells how to get your outpatient prescription drugs through our plan.
    - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.

When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time"

  - meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call Member Services for more information.

- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Evidence of Coverage* more information about network pharmacies.

Table of Contents

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information**. This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under NJ FamilyCare. These drugs are included in the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

   Here are some times when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug

   For more information about asking us to pay you back for a drug, refer to **Chapter 7** *o*f your *Evidence of Coverage*.

3. **Send us information about payments others have made for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

When you get an EOB in the mail, make sure it is complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call Member Services or read the *Evidence of Coverage,* please see the website at the bottom of the page.

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at our Plans Member Services number at the bottom of the page. You can also find answers to many questions on our website: **HorizonBlue.com/Medicare.**

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at our Plans Member Services.
- Or call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules. Refer to **Chapter 9** of the *Evidence of Coverage* to learn about how to file an appeal if you are told a drug will not be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of your *Evidence of Coverage* and our *Provider and Pharmacy Directory*.

C1. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is a 90 day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Evidence of Coverage* or our *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers adult Medicare Part D vaccines at no cost to you.

D1. What you need to know before you get a vaccination

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination.

D2. What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage.*
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you will pay nothing.
   - For other Part D vaccines, you pay nothing for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.

3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you will pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay nothing for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

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A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow our Plan providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to Section B of this Chapter.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
    - If you paid for services covered by Medicare, we will pay you back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
       - If the provider should be paid, we will pay the provider directly.
       - If you already paid for the Medicare service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services. **Call Member Services** at the number at the bottom of this page **if you get any bills.**

- Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. If you are retroactively enrolled in our Plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of your *Evidence of Coverage* to learn more about out-of-network pharmacies.

5. When you pay the prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full

prescription cost yourself or return to the pharmacy with your Member ID Card.

- Send us a copy of your receipt when you ask us to pay you back.

6. When you pay the full prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Evidence of Coverage*).
    - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Evidence of Coverage*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Evidence of Coverage*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You must send your information to us within 36 months of the date you received the service, item, or drug.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.

- You can get the form on our website (**HorizonBlue.com/Medicare**), or you can call Member Services and ask for the form.

Mail your request for payment together with any bills or receipts to this address:

For Medical Care:
Horizon NJ TotalCare (HMO D-SNP)
Claims Processing Department
P.O. Box 24080
Newark, NJ 07101-0406

For Prescription Drugs:
Prime Therapeutics, LLC
P.O. Box 20970
Lehigh Valley, PA 18002-0970

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our Plan covers your service, item, or drug.

- We will let you know if we need more information from you.
- If we decide that our Plan covers the service, item, or drug and you followed all the rules for getting it, we will pay for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you haven't paid, we will pay the provider directly.

Chapter 3 of your *Evidence of Coverage* explains the rules for getting your services covered.
Chapter 5 of your *Evidence of Coverage* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal
- To learn more about coverage decisions, refer to **Chapter 9**.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.”

- The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** *o*f your *Evidence of Coverage.*
- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our Plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our Plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our Plan.

- To get information in a way that you can understand, call Member Services. Our Plan has free interpreter services available to answer questions in different languages.
- Our Plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services or write to:

  Horizon NJ TotalCare (HMO D-SNP)
  Member Services
  P.O. Box 24081
  Newark, NJ 07101-0406

- Our Plan can also provide written materials in Spanish.
- To request materials in language other than English and/or alternate format, please call member services at **1-800-543-5656** (TTY users should call 711) 24 hours, 7 days a week. The call is free.
- Your preferred language and/or format request is captured at the time of enrollment and we will keep your language/preference on file for future requests. You can also make a standing request for materials to be in Spanish and/or in a particular format. This will be sent by mail or other available methods. You have the option to change your preference at any time by calling Member Services at **1-800-543-5656** (TTY **711**), 24 hours a day, 7 days a week.

If you have trouble getting information from our Plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at **1-800-MEDICARE (1-800-633-4227).** You can call 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- You can also contact the state's NJ FamilyCare program with a complaint by calling the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) at **1-800-701-0710** (TTY: **711**).

- Office for Civil Rights at 1**-800-368-1019**. TTY users should call **1-800-537-7697.**

A. Tiene derecho a obtener servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que **todos los** servicios se le proporcionen de una manera culturalmente competente y accesible. También debemos hablarle acerca de los beneficios de nuestro plan y sus derechos de una manera que usted pueda entender. Debemos informarle sobre sus derechos cada año que usted esté en nuestro plan.

- Para obtener la información de una manera que usted pueda entender, llame al Servicios para miembros. Nuestro plan cuenta con servicios gratuitos de intérpretes a su disposición para responder preguntas en diferentes idiomas.

- Nuestro plan también le puede brindar materiales en otros idiomas que no sean el inglés y en formatos como letra grande, Braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame al Servicios para miembros o escriba a:

  Horizon NJ TotalCare (HMO D-SNP)
  Member Services
  P.O. Box 24081
  Newark, NJ 07101-0406

  - Nuestro plan también puede proporcionar materiales escritos en español.

  - Para solicitar materiales en otro idioma que no sea inglés y/o en formato alternativo, llame a Servicios para miembros al **1-800-543-5656** (los usuarios de TTY deben llamar al **711**) las 24 horas del día, los 7 días de la semana. La llamada es gratis.

  - Si un miembro había solicitado una Evidencia de cobertura (Evidence of Coverage, EOC), Directorio de proveedores y Formulario en español el año pasado, enviaremos esos documentos para el año actual del plan en el mismo idioma.

Si tiene dificultades para obtener información sobre nuestro plan debido a problemas relacionados con el idioma o una discapacidad y desea presentar una queja, llame a:

- Medicare al **1-800-MEDICARE (1-800-633-4227).** Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al **1-877-486-2048**.
- También puede comunicarse con el programa estatal NJ FamilyCare si tiene una queja llamando al Departamento de Servicios Humanos de Nueva Jersey, División de Asistencia Médica y Servicios de Salud (Division of Medical Assistance and Health Services, DMAHS) al **1-800-701-0710** (TTY: **711**).
- Oficina para los Derechos Civiles al 1**-800-368-1019**. Los usuarios de TTY deben llamar al **1-800-537-7697.**

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our Plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Evidence of Coverage*.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP. We do **not** require you to referrals to go to network providers.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Evidence of Coverage*.

Chapter 9 of your *Evidence of Coverage* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our Plan. It also includes your medical records and other medical and health information.

You have a right to be treated with respect and recognition of your dignity and you have a right to privacy.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our Plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

https://www.horizonblue.com/hipaa-notice-of-privacy-practices

Changes to the terms of this Notice

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

- **FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED**

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

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

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

    Or calling **1-800-658-6781 (Compliance Hotline which can be anonymous)**

  - You can file a complaint with:

    U.S. Department of Health and Human Services Office for Civil Rights
    200 Independence Avenue,
    S.W. Washington, D.C. 20201

    Or calling **1-877-696-6775** Or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**

If you have any questions regarding the content of this Notice, you may call Member Services at **1-800-543-5656** (TTY users should call **711**).

D. Our responsibility to give you information

As a member of our Plan, you have the right to get information from us about our Plan, our network providers, and your covered services and your member rights and responsibilities.

If you don't speak English, we have interpreter services to answer questions you have about our Plan. To get an interpreter, call Member Services. Our Plan can also provide written materials in Spanish. This is a free service to you. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our Plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our Plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Evidence of Coverage*) and drugs (refer to **Chapters 5 and 6** of your *Evidence of Coverage*) covered by our Plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Evidence of Coverage*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

- **We also review new medical technology for the purpose of deciding its eligibility for coverage. This broad process includes input from the professional and medical community, including input from doctors and other health care professionals in New Jersey, as well as the results of literature research such as newspapers, books and magazines. In addition, we review current policies about existing technology and change them as necessary.**

- **Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.**

- **Follow plans and instructions for care that you agreed upon with your physician. Provide information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.**

- **Contact Information to reach the Utilization Management (UM) Department to assist with inquiries/requests:**

    - The UM team may be reached **at 1-800-664-BLUE (2583)** (TTY users call **711**). Monday through Friday 8 a.m. to 5 p.m. For urgent inquiries, including those after business hours and on weekends, our on-call staff can be reached at **1-844-778-6673** (TTY users should call **711**). Staff will identify themselves by name, title and the Plan when calling you about a coverage decision.

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Evidence of Coverage*.

F. Your right to leave our Plan

No one can make you stay in our Plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Evidence of Coverage:*
    - For more information about when you can join a new MA or prescription drug benefit plan.
    - For information about how you will get your NJ FamilyCare benefits if you leave our Plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.

- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our Plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Evidence of Coverage* tells how to ask us for a coverage decision.
- To make recommendations regarding the organization's member rights and responsibilities policy.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

Call Member Services for more information.

G3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Livanta BFCC-QIO Program, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105; telephone number: **1-866-815-5440;** TTY: **1-866-868-2289**.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of your *Evidence of Coverage* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services **1-800-543-5656** (TTY users should call **711**) to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Evidence of Coverage* – or you want more information about your rights, you can call:

Member Services. You can find your Rights and Responsibilities on our websites at **https://www.horizonblue.com/members/education-center/member-rights-and-responsibilities.**

- The SHIP program at **1-800-792-8820**. For more details about the SHIP, refer to Chapter 2, Section **C**.
- The Ombudsperson Program at **1-800-446-7467**. For more details about this program, refer to **Chapter 2** of your *Evidence of Coverage*.

Medicare at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)**

You can also contact the New Jersey Medicaid program for assistance. You can call the NJ Department of Human Services, Division of Medical Assistance and Health Services at **1-800-701-0710** (TTY**: 711**).

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the** *Evidence of Coverage* to learn what our Plan covers and the rules to follow to get covered services and drugs. For details about your:
    - Covered services, refer to **Chapters 3 and 4** of your *Evidence of Coverage.* Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
    - Covered drugs, refer to **Chapter 5 and 6** of your *Evidence of Coverage.*
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our Plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:

- **If you get any services or drugs that are not covered by our Plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area, you cannot stay in our Plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Evidence of Coverage* tells about our service area.
  - We can help you find out if you're moving outside our service area.
  - Tell Medicare and NJ FamilyCare your new address when you move. Refer to **Chapter 2** of your *Evidence of Coverage* for phone numbers for Medicare and NJ FamilyCare.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- **Call Member Services for help if you have questions or concerns.**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your Plan.
- You need a service, item, or medication that your Plan said it won't pay for.
- You disagree with a decision your Plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- "Making a complaint" instead of "filing a grievance"
- "Coverage decision" instead of "organization determination", "benefit determination", "at-risk determination", or "coverage determination"
- "Fast coverage decision" instead of "expedited determination"
- "Independent Review Organization" (IRO) instead of "Independent Review Entity" (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the State Health Insurance Assistance Program (SHIP)

You can call the SHIP. The SHIP counselors can answer your questions and help you understand what to do about your problem. The SHIP is not connected with us or with any

insurance company or health plan. The SHIP has trained counselors in every county, and services are free. The SHIP phone number is **1-800-792-8820 (TTY: 711).**

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048.**
- Visit the Medicare website (**www.medicare.gov**).

Help and information from the NJ Department of Human Services, Division of Medical Assistance and Health Services (the New Jersey Medicaid program)

You can get help and information from the Division of Medical Assistance and Health Services (the New Jersey Medicaid program) by calling **1-800-701-0710** (TTY: **711**). Their website can be found at **www.state.nj.us/humanservices/dmahs/**.

C. Understanding Medicare and NJ FamilyCare complaints and appeals in our Plan

You have Medicare and NJ FamilyCare. Information in this chapter applies to **all** of your Medicare and NJ FamilyCare benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and NJ FamilyCare processes.

Sometimes Medicare and NJ FamilyCare processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for an NJ FamilyCare benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that applies to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** "Coverage decisions and appeals."	**No.** My problem is not about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage for your medical services or drugs. For example, if your Plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section G** of your *Evidence of Coverage).*

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you. In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or NJ FamilyCare. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals. If your problem is about a coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- The State Health Insurance Assistance Program (SHIP), which can be reached at **1-800-792-8820** (TTY: **711**).
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at HorizonBlue.com/Medicare. You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D prescription drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Evidence of Coverage.* We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items, behavioral health services, and MLTSS services, as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.

   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **"integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: **1-800-543-5656** TTY: **711**

- Faxing: **609-583-3028**

- Writing: Horizon NJ TotalCare Appeals and Grievances
  P.O. Box 24079
  Newark, NJ 07101-0406

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a**:**

- Medical service or item within 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

> The legal term for "fast coverage decision" is "**expedited determination**."

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-800-543-5656** (TTY users should call **711).**

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-800-543-5656** (TTY users should call **711).**

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf***:* or on our website at **HorizonBlue.com/Medicare**.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
    - If we need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
    - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. *The* first is called an IURO appeal. The IURO is *the state's Independent Utilization Review Organization. The other option* is called a Fair Hearing. Section F4 includes a detailed explanation of these two options, starting on page 194**.**
- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
    - If we need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
    - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
    - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options, starting on page 194.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a NJ FamilyCare service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, NJ FamilyCare, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that NJ FamilyCare usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and NJ FamilyCare** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by NJ FamilyCare, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:

- Authorize the medical care coverage **within 72 hours, or**
- Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**
- Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and NJ FamilyCare

A Level 2 Appeal for services that NJ FamilyCare usually covers gives you two options. One option is an appeal with the IURO, the state's Independent Utilization Review Organization. The second option is a Fair Hearing with the state. You must request an IURO appeal **within 60**

calendar days of the date we sent the decision letter on your Level 1 Appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

How do I request an IURO appeal?

- The Independent Utilization Review Organization (IURO) is an independent organization that is hired by the State of New Jersey's Department of Banking and Insurance (DOBI). This organization is not connected with us, and it is not a government agency. This organization is chosen by the DOBI to serve as an independent reviewer for medical appeals, and the DOBI administers the IURO appeal process. A review by the IURO is also sometimes called an "IURO appeal" or an "External Appeal".
- The IURO will typically not review cases based on the following services:
    - assisted living program
    - assisted living services - when the denial is not based on medical necessity
    - caregiver/participant training
    - chore services
    - community transition services
    - home based supportive care
    - home-delivered meals
    - personal care assistance (PCA)
    - respite (daily and hourly)
    - social day care
    - structured day program -- when the denial is not based on medical necessity
    - supported day services -- when the denial is not based on the diagnosis of TBI
- The IURO appeal process is optional. You can request an IURO appeal, and wait to receive the IURO's decision, before you request a Fair Hearing. Or, you can request an

IURO appeal and a Fair Hearing at the same time (the requests are made to two different organizations). **You are not required to request an IURO appeal before requesting a Fair Hearing.**

- You can request an IURO appeal yourself, or it can be requested by your Authorized Representative (which includes your provider, if they are acting on your behalf with your written consent).

- You can request an IURO appeal by filling out the External Appeal Application form. A copy of the External Appeal Application form will be sent to you with the decision letter for your Level 1 Appeal. You must send this form to the following address **within 60 calendar days** of the date we sent the decision letter on your Level 1 Appeal:

Maximus Federal – NJ IHCAP

3750 Monroe Avenue, Suite 705

Pittsford, New York 14534

You may also fax the form to **585-425-5296**, or email a completed copy of the form to Stateappealseast@maximus.com.

- If you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your IURO appeal, you must request the IURO appeal **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.

- If the IURO reviews your case, it will reach a decision **within 45 calendar days** (or sooner, if your medical condition makes it necessary). If your IURO appeal is a "fast" appeal, the IURO will reach a decision **within 48 hours**.

- If you have questions about the IURO appeal process and/or need assistance with your application, you can call the New Jersey Department of Banking and Insurance toll-free at **1-888-393-1062** or **609-777-9470**.

How do I request a Fair Hearing?

- You must ask for a Fair Hearing in writing **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

- If you ask for an expedited or "fast" Fair Hearing, and you meet all of the requirements for a "fast" hearing, a decision will be made within 72 hours of the agency's receipt of your hearing request.

- However**,** if you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your Fair Hearing, you must request that your benefits be continued **in writing** on your Fair Hearing request, and you must send your request **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.

Or, if you asked for an IURO appeal and received an adverse decision before requesting a Fair Hearing, you must send this written request **within 10 calendar days** of the date on the letter informing you of the adverse decision on your IURO appeal.

Please note that if you ask to have your services or items continue during a Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of the services or items.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.

- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our Plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of your *Evidence of Coverage*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your

appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.

- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and NJ FamilyCare usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4**, starting on page 192, for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our Plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that NJ FamilyCare may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Evidence of Coverage* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that is not on our Plan's Drug List or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our Plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?

You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4.**	Refer to **Section G4**.	Refer to **Section G4.**	Refer to **Section G5.**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List**
2. **Removing a restriction for a covered drug**
   - Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Evidence of Coverage* for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
   - Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

Ask for the type of coverage decision you want by calling **1-800-543-5656** (TTY users should call **711**) writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.

- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Evidence of Coverage*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.

- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K.**

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.

- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our Plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling **1-800-543-5656** (TTY users should call **711**) writing, or faxing us. You, your representative, or your doctor (or other

prescriber) can do this. Please include your name, contact information, and information regarding your appeal.

- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6**

for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO . The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our Plan's hospital coverage, refer to **Chapter 4** of your *Evidence of Coverage.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048.**

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.
    - Know where to report any concerns you have about the quality of your hospital care.
    - Appeal if you think you're being discharged from the hospital too soon.

- **Sign the notice** to show that you got it and understand your rights.
    - You or someone acting on your behalf can sign the notice.
    - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit **www.cms.gov/Medicare/Medicare-General-Information/BNI.**

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our Plan.

In New Jersey, the QIO is Livanta. Call them at **1-866-815-5440** (TTY: **1-866-868-2289**). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.

- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our Plan directly instead. Refer to **Section G4** for information about making an appeal to us.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**).

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our Plan gave them.
- By noon of the day after reviewers tell our Plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or **1-800-MEDICARE (1-800-633-4227**), 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) You can also refer to a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI**.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-866-815-5440** (TTY: **1-866-868-2289**).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H4. Making a Level 1 Alternate Appeal

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

> The legal term for "fast review" or "fast appeal" is **"expedited appeal".**

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.

- We will not pay any of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**

- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our Plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**).
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Evidence of Coverage* for more information about the QIO and how to contact them.

- Ask them to review your appeal and decide whether to change our Plan's decision.

- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4.**

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or get a copy online at **www.cms.gov/Medicare/Medicare-General-Information/BNI**.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.

- Reviewers look at your medical information, talk with your doctor, and review information that our Plan gave them.

- Our Plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-866-815-5440** (TTY: **1-866-868-2289**).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review".

> The legal term for "fast review" or "fast appeal" is **"expedited appeal".**

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- We agree to pay you back for the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
    - Our coverage for these services ends on the date we told you.
    - We will not pay any of the costs after this date.
    - You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
    - We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal:

- We send the information for your Level 2 Appeal to the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.
- If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.
- The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you

can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional NJ FamilyCare appeals

You may also have other appeal rights if your appeal is about services or items that NJ FamilyCare usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our Plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.

Complaint	Example
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our Plan. An external complaint is filed with and reviewed by an organization not affiliated with our Plan. If you need help making an internal and/or external complaint, you can call Member Services at **1-800-543-5656** (TTY users should call **711**).

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at **1-800-543-5656** (TTY users should call **711**). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- **For complaints about Medical Care and Services:**
  - We have 30 calendar days from the date we receive your grievance (complaint) to resolve the complaint and notify you of our decision.

- We may use a 14-day extension if we require further research into the issue and it is in your best interest to continue to research.
- We will notify you by letter if we take a 14-day extension.
- **If making an oral complaint:** Have the following prepared for the representative:
  - Your name
  - Your address
  - Your phone number where you can be reached if we need to contact you about your complaint
  - Your Member ID Number
  - A description of your complaint/grievance
- **If you are sending your complaint in writing:** Include the following in your letter:
  - Your name
  - Your address
  - Your phone number where you can be reached if we need to contact you about your complaint
  - Your Member ID Number
  - A description of your complaint/grievance
  - Send it to:
    Horizon NJ TotalCare Appeals and Grievances
    P.O. Box 24079
    Newark, NJ 07101-0406

- **You may file an expedited grievance (complaint) if:**
  - We deny your request for a fast (expedited) decision about your request for a service.
  - We deny your request for a fast (expedited) appeal for a service.
  - We need to take extra days (take an extension) to decide on your request for a service.
  - We need to take extra days (take an extension) to consider your appeal for a service.
  - If we deny your request to a fast (expedited) decision or if we need to take extra days (take an extension) to resolve your grievance, you will receive a letter that explains you may file an expedited grievance. We will respond to your expedited grievance within 24 hours with our decision.

- **For complaints about Part D Prescription Drugs:**
    - We have 30 calendar days from the date we receive your grievance (complaint) to resolve the complaint and notify you of our decision.
    - We may use a 14-day extension if we require further research into the issue and it is in your best interest to continue to research.
    - We will notify you by letter if we take a 14-day extension.
    - **If making an oral complaint:** Have the following prepared for the representative:
        - Your name
        - Your address
        - Your phone number where you can be reached if we need to contact you about your complaint
        - Your Member ID Number
        - A description of your complaint/grievance

If you are sending your complaint in writing: Include the following in your letter:

- Your name
- Your address
- Your phone number where you can be reached if we need to contact you about your complaint
- Your Member ID Number
- A description of your complaint/grievance
- Send it to:

Prime Therapeutics, LLC
Medicare Member Research Team
10802 Farnam Drive
Omaha, NE 68154

The legal term for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in

writing. We also provide a status update and estimated time for you to get the answer.

- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: **www.medicare.gov/MedicareComplaintForm/home.aspx.** You do not need to file a complaint with NJ TotalCare (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call **1-800-MEDICARE (1-800-633-4227).** TTY users can call 1**-877-486-2048.** The call is free.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is **1-800-368-1019.** TTY users should call **1-800-537-7697**. You can visit **www.hhs.gov/ocr** for more information.

You may also contact the local OCR office at:

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Customer Response Center: **1-800-368-1019**
Fax: **202-619-3818**
TDD: **800-537-7697**
Email: **ocrmail@hhs.gov**

You may also have rights under the Americans with Disability Act (ADA) and under the New Jersey Law Against Discrimination, N.J.S.A. 10:5-12; the Medical Assistance and Health Services Act, N.J. Rev Stat § 30:4D-9.1 (2017).

You can contact the ADA Information Line at:

ADA Information Line
1-800-514-0301
1-833-610-1264 (TTY)
Monday, Tuesday, Wednesday, Friday - 9:30 a.m. to 12:00 p.m. and 3pm – 5:30pm ET
Thursday 2:30 – 5:30pm ET

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our Plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Evidence of Coverage*.

In New Jersey, the QIO is called Livanta. The phone number for Livanta is **1-866-815-5440** (TTY: **1-866-868-2289**).

Chapter 10: Ending your membership in our Plan

Introduction

This chapter explains how you can end your membership with our Plan and your health coverage options after you leave our Plan. If you leave our Plan, you will still be in the Medicare and NJ FamilyCare (Medicaid) programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

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A. When you can end your membership in our Plan

Most people with Medicare can end their membership during certain times of the year. Since you have NJ FamilyCare, you may be able to end your membership with our Plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our Plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our Plan ends on December 31 and your membership in the new plan starts on January 1.

- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you move out of our service area,

- your eligibility for NJ FamilyCare or Extra Help changed, **or**

- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our Plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our Plan, you can get information about your:

- Medicare options in the table in **Section C1.**

- Medicaid services in **Section C2.**

You can get more information about how you can end your membership by calling Member Services.

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- The State Health Insurance Assistance Program (SHIP), at **1-800-792-8820** (TTY **711**).

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to Chapter 5 of your Evidence of Coverage for information about drug management programs.

B. How to end your membership in our Plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our Plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our Plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call **1-877-486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our Plan is in the chart on page 234.

C. How to get Medicare and NJ FamilyCare services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our Plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our Plan.**1. You can change to:** **Another Medicare health plan**	**Here is what to do:** Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call **1-855-921-PACE (7223).** If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY **711**). **OR** Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Horizon NJ Health for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another dual eligible special needs plan (D-SNP) plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (TTY**: 711**)**.**

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY **711**). **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our Plan when your Original Medicare coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Horizon NJ Health for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (TTY: **711**).

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the State Health Insurance Assistance Program at **1-800-792-8820,** Monday through Friday from 8:30 a.m. to 4:30 p.m. For more information or to find a local SHIP office in your area, please visit **http://www.state.nj.us/humanservices/doas/services/ship/**	**Here is what to do:** Call Medicare at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY **711**). You are automatically disenrolled from our Plan when your Original Medicare coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Horizon NJ Health for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (TTY: **711**).

C2. Your NJ FamilyCare services

If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Horizon NJ Health for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (**TTY: 711**).

D. Your medical services and drugs until your membership in our Plan ends

If you leave our Plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our Plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Horizon NJ TotalCare (HMO D-SNP) ends, our Plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Other situations when your membership in our Plan ends

These are cases when we must end your membership in our Plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our Plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our Plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.

- You must be a United States citizen or lawfully present in the United States to be a member of our Plan.
- The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
- We must disenroll you if you don't meet this requirement.

If you are within our Plan's two-month (60 day) period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, Medicaid-only benefits may not be covered by our Plan. To find out if a benefit is Medicaid-only, and/or to find out if it will be covered, you can call Member Services. All of your Medicare services, including Medicare Part D prescription drugs, will continue to be covered at $0 cost-sharing (no copayments, coinsurance, or deductibles) during the period of deemed continued eligibility.

We can make you leave our Plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our Plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our Plan for any health-related reason

We cannot ask you to leave our Plan for any reason related to your health. If you think we're asking you to leave our Plan for a health-related reason, **call Medicare** at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

G. Your right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Evidence of Coverage* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our Plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage.*

Table of Contents

A. Notice about laws

Many laws apply to this *Evidence of Coverage*. These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Evidence of Coverage*. The main laws that apply are federal laws about the Medicare and NJ FamilyCare (Medicaid) programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our Plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at **1-800-368-1019**. TTY users can call **1-800-537-7697**. You can also visit **www.hhs.gov/ocr** for more information.
- Call your local Office for Civil Rights.

  Office for Civil Rights
  U.S. Department of Health and Human Services
  Jacob Javits Federal Building
  26 Federal Plaza - Suite 3312
  New York, NY 10278
  Customer Response Center: **1-800-368-1019**
  Fax: **202-619-3818**
  TDD: **800-537-7697**
  Email: **ocrmail@hhs.gov**

- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and NJ FamilyCare as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that NJ FamilyCare is the payer of last resort.

D. Notice about coverage during unforeseen circumstances

Provision of benefits and services under our Plan could be delayed or rendered impracticable by circumstances not reasonably within the control of Horizon Healthcare of New Jersey, Inc., network providers, network pharmacies or network facilities, such as: an epidemic; a terrorist event; a major disaster; the complete or partial destruction of facilities because of war; riot or civil insurrection; the disability of a significant number of providers or pharmacies; or similar causes. In this event, neither Horizon Healthcare of New Jersey, Inc. nor any provider or pharmacy shall have any liability or obligation for delay or failure to provide such services provided they have, in good faith, used their best efforts to render services to the extent practicable: 1) according to their best judgment: and 2) within the limitation of the facilities and personnel then available. Coverage during a federal disaster or other public health emergency declaration will be provided pursuant to CMS requirements.

E. Blue Cross Blue Shield Association Subscriber Notice

Subscriber hereby expressly acknowledges its understanding this evidence of coverage ("EOC") constitutes a contract solely between Subscriber and Horizon Blue Cross Blue Shield of New Jersey, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Horizon BCBSNJ to use the Blue Cross and/or Blue Shield Service Marks in the State of New Jersey, and that Horizon BCBSNJ is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this EOC based upon representations by any person other than Horizon BCBSNJ and that no person, entity, or organization other than Horizon BCBSNJ shall be held accountable or liable to Subscriber for any of Horizon BCBSNJ obligations to Subscriber created under this EOC. This paragraph shall not create any additional obligations whatsoever on the part of Horizon BCBSNJ other than those obligations created under other provisions of this agreement.

- **Exhausted benefits**
    - If covered benefits are exhausted while a member continues to need care, the organization notifies the member about alternatives and resources for continuing care and how to obtain it, as appropriate. The organization is not required to develop alternative resources.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Evidence of Coverage* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** *of your Evidence of Coverage* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Evidence of Coverage* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services. **Chapter 9** of your *Evidence of Coverage* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our Plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our Plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops.

Disenrollment: The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our Plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic

supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

***Evidence of Coverage* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our Plan.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that are not covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy”, or “LIS”.

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you for services. Call Member Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you do **not** owe any cost-sharing. Providers should not bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary".

Managed Long-term services and supports (MLTSS): Managed Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. MLTSS includes Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our Plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a "dually eligible individual".

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare prescription drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our Plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

Member (member of our Plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Services: A department in our Plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Evidence of Coverage* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our Plan members. We call them "network pharmacies" because they agreed to work with our Plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you're a member of our Plan, you must use network providers to get covered services. Network providers are also called "plan providers".

NJ FamilyCare: This is the name of New Jersey's Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of your *Evidence of Coverage*.

Organization determination: Our Plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of your *Evidence of Coverage* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our Plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our Plan to coordinate or provide covered drugs to members of our Plan. Our Plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our Plan and is not under contract to provide covered services to members of our Plan. **Chapter 3** of your *Evidence of Coverage* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Evidence of Coverage* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our Plan may not cover the service or drug if you don't get approval first.

Our Plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our Plan's PA are marked in **Chapter 4** of your *Evidence of Coverage*.

Our Plan covers some drugs only if you get PA from us.

- Covered drugs that need our Plan's PA are marked in the *List of Covered Drugs*.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Evidence of Coverage* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes alternative drugs that may be used for the same health condition as a given drug and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Evidence of Coverage*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Evidence of Coverage* to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our Plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Fair Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Fair Hearing. If the State Fair Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Horizon NJ TotalCare (HMO D-SNP) Member Services

Type	Details
CALL	**1-800-543-5656** Calls to this number are free. Hours of Operation*:* 24 hours a day, 7 days a week. **For Prescription Drugs**: **1-855-457-1346** Hours of Operation*:* 24 hours a day, 7 days a week. For **Horizon Extra Benefits Card- Member Services**, please call **1-800-480-6598** Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation*:* 24 hours a day, 7 days a week.
WRITE	Horizon NJ TotalCare (HMO D-SNP) Member Services P.O. Box 24081 Newark, NJ 07101-0406 **For Prescription Drugs**: Prime Therapeutics, LLC 10802 Farnam Drive Omaha, NE 68154 **Horizon Extra Benefits Card** Member Services 4613 N. University Dr. #586 Coral Springs, FL 33067
WEBSITE	**HorizonBlue.com/Medicare**

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