Your Benefits and Services

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

You pay little or nothing for the medical care and services you get through Horizon NJ Health. Make sure you know how Horizon NJ Health works, especially when it comes to emergency care, seeing your doctor and when you need an authorization. If you get services that are not covered by Horizon NJ Health or authorized by your PCP, you may be billed. Before care is given, your doctor should tell you if a service is not covered and if you will be billed.

If you are not sure whether a service is covered, call Member Services at **1-800-682-9090** (TTY **711**).

Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Abortions	Covered by FFS.* Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests			
Acupuncture	Covered			
Autism Services	Covered by Horizon NJ Health and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include Applied Behavioral Analysis (ABA) treatment, augmentative and alternative communication services and devices, Sensory Integration (SI) services, allied health services (physical therapy, occupational therapy and speech therapy), and Developmental Relationship based services including but not limited to DIR, DIR Floortime and the Greenspan approach therapy.			
Blood & Blood Products	Covered Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.			
Bone Mass Measurement	Covered Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			
Cardiovascular Screenings	Covered For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.			
Chiropractic Services	Covered Covers manipulation of the spine.			
Colorectal Screening	Covered Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 45 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer. • *Barium Enema* – Covered When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months. • *Colonoscopy* – Covered Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy. • *Fecal Occult Blood Test* – Covered Covered once every 12 months. • *Flexible Sigmoidoscopy* – Covered Covered once every 48 months.			

*Fee-for-Service

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Dental Services	Covered Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. 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). Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. Children should have their first dental exam when they are a year old, or when they get their first tooth, whichever comes first. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through the age of three (3) years old. If additional care is needed, members can find a complete list of dentists who treat children 6 years of age or younger in *The NJFC Directory of Dentists Treating Children Under the Age of 6*. This separate list of dentists is located at horizonNJhealth.com/kidsdentists.		Covered Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. 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). Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. Children should have their first dental exam when they are a year old, or when they get their first tooth, whichever comes first. The NJ Smiles program allows non-dental providers to perform oral screenings, caries risk assessments, anticipatory guidance and fluoride varnish applications for children through the age of three (3) years old. If additional care is needed, members can find a complete list of dentists who treat children 6 years of age or younger in *The NJFC Directory of Dentists Treating Children Under the Age of 6*. This separate list of dentists is located at horizonNJhealth.com/kidsdentists. **NJ FamilyCare C and D members have a $5 copay per dental visit (except for diagnostic and preventive services).**	

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Diabetes Screenings	Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.			
Diabetes Supplies	Covered Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.			
Diabetes Testing and Monitoring	Covered Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.			
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.			
Durable Medical Equipment (DME)	Covered			
Emergency Care	Covered Covers emergency department and physician services.		Covered Covers emergency department and physician services. **NJ FamilyCare C members have a $10 copay.**	Covered Covers emergency department and physician services. **NJ FamilyCare D members have a $35 copay.**

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Your Benefits and Services (continued)

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

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Hearing Services/ Audiology	Covered Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.			
Home Health Agency Services	Covered Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.			
Hospice Care Services	Covered Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. • Covered in the community as well as in institutional settings. • Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for members under 21 years of age shall cover both palliative and curative care. **NOTE: Any care unrelated to the member's terminal condition is covered in the same manner as it would be under other circumstances**.			
Immunizations	Covered Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.			
Inpatient Hospital Care	Covered Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital. • *Acute Care* – Covered Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance). • *Psychiatric – For coverage details, please refer to the Behavioral Health chart.*			
Mammograms	Covered Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.			

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Maternal and Child Health Services	Covered Covers medical services for perinatal care, and related newborn care and hearing screenings, including midwifery care, Centering Pregnancy, immediate postpartum LARC (Long-Acting Reversible Contraception) and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.			
Medical Day Care (Adult Day Health Services)	Covered A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	*Not covered*		
Nurse Midwife Services	Covered		Covered **$5 copay for each visit (except for prenatal care visits)**	

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Nursing Facility Services	Covered Members may have patient pay liability. • *Long Term (Custodial Care)* – Covered. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability. • *Nursing Facility (Hospice)* – Covered. Hospice care can be covered in a Nursing Facility setting. *See Hospice Care Services. • *Nursing Facility (Skilled)* – Covered. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting. • *Nursing Facility (Special Care)* – Covered. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	*Not covered*		
Organ Transplants	Covered Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.			
Outpatient Surgery	Covered			

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Outpatient Hospital/ Clinic Visits	Covered		Covered **$5 copay per visit (no copay if the visit is for preventive services).**	
Outpatient Rehabilitation *(Occupational Therapy, Physical Therapy, Speech Language Pathology)*	Covered Covers physical therapy, occupational therapy, speech pathology and cognitive rehabilitation therapy.	Covered Covers physical, occupational, and speech/language therapy. ***Limited to 60 days per therapy per calendar year.***		
Pap Smears and Pelvic Exams	Covered Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.			
Personal Care Assistance	Covered Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	*Not covered*		
Podiatry	Covered Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. ***Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.***		Covered Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. **$5 copay per visit** ***Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.***	

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Prescription Drugs	Covered Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.		Covered Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered. **There is a $1 copay for generic drugs, and a $5 copay for brand name drugs**.	
Physician Services – Primary and Specialty Care	Covered. Covers medically necessary services and certain preventive services in outpatient settings.		Covered Covers medically necessary services and certain preventive services in outpatient settings. **$5 copay for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care and pap smears, when appropriate).**	
Private Duty Nursing	Covered Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. **Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).**			
Prostate Cancer Screening	Covered Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.			
Prosthetics and Orthotics	Covered Coverage includes (but is not limited to) arm, leg, back and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids and dentures.			
Renal Dialysis	Covered			
Routine Annual Physical Exams	Covered			

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Smoking/Vaping Cessation	Covered Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: • NJ Quitline: Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS** (**1-866-657-8677**) (TTY **711**), weekdays, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at njquitline.org.			
Transportation (Emergency) *(Ambulance, Mobile Intensive Care Unit)*	Covered Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.			
Transportation (Non-Emergent) *(Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)*	Covered by FFS. Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement for mileage, are also covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimbursement are covered. May require medical orders or other coordination by Horizon NJ Health, PCP, or providers. **Modivcare transportation services are covered for NJ FamilyCare A, ABP, B, C or D members. All transportation including livery is available for *all* members including B, C and D.**			
Urgent Medical Care	Covered Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).		Covered Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). **NOTE: There may be a $5 copay for urgent medical care provided by a physician, optometrist, dentist or nurse practitioner**.	

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Your Benefits and Services (continued)

Service Benefit	NJ FamilyCare A/ABP	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Vision Care Services	Covered Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.		Covered Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration. **$5 copay per visit for Optometrist services.**	
• *Corrective Lenses –*	Covered Covers 1 pair of lenses/frames or contact lenses every 24 months for members age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.			

Behavioral health benefits

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

Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mental Health					
Adult Mental Health Rehabilitation *(Supervised Group Homes and Apartments)*	Covered	Covered by FFS.	Not covered		
Inpatient Psychiatric	Covered Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF)** or critical access hospital.				

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Your Benefits and Services (continued)

Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mental Health					
Independent Practitioner Network or IPN *(Psychiatrist, Psychologist or APN)*	Covered	Covered by FFS.			
Outpatient Mental Health	Covered	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient** setting, **Mental Health Outpatient Clinic/Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.			
Partial Care *(Mental Health)*	Covered	Covered by FFS. ***Limited to 25 hours per week (5 hours per day, 5 days per week).*** ***Prior authorization required.***			
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered	Covered by FFS. ***Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge.*** ***Prior authorization required for Acute Partial Hospitalization.***			
Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES)	Covered by FFS.				

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Your Benefits and Services (continued)

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

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Your Benefits and Services (continued)

Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Substance Use Disorder					
Opioid Treatment Services	Covered	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment**. Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.			
Peer Recovery Support Services	Covered	Covered by FFS. Includes coverage for Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment. Coverage for Non-Methadone Medication Assisted Treatment includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.			
Substance Use Disorder Intensive Outpatient (IOP) *ASAM 2.1*	Covered	Covered by FFS.			
Substance Use Disorder Outpatient (OP) *ASAM 1*	Covered	Covered by FFS.			
Substance Use Disorder Partial Care (PC) *ASAM 2.5*	Covered	Covered by FFS.			
Substance Use Disorder Short Term Residential (STR) *ASAM 3.7*	Covered	Covered by FFS.			

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

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

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

Nondiscrimination Policy

Read about Horizon NJ Health's nondiscrimination policy.

Getting Help in Your Language

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

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