

- i. For NJ FamilyCare-Plans B and C participants, coverage shall include EPSDT: medical examinations, dental, vision, hearing, and lead screening services. Coverage includes only those treatment services identified through the examination that are available under the MCO's benefits package for Plans B and C enrollees or as services specified under the FFS program;
- 4. Emergency medical care;
- 5. Inpatient hospital services including acute care hospitals, rehabilitation hospitals and special hospitals;
- 6. Outpatient hospital services;
- 7. Laboratory services, not including routine testing related to administration of Clozapine and other specified atypical antipsychotic drugs listed in the managed care contract for non-DDD clients;
- 8. Radiology services, diagnostic and therapeutic;
- 9. Prescription drugs, including legend drugs and non-legend drugs that are covered by the Medicaid program and indicated in the managed care contract;
- 10. Family planning services and supplies;
- 11. Audiology services;
- 12. Inpatient rehabilitation services;
- 13. Podiatrist services;
- 14. Chiropractor services;
- 15. Optometrist services;
- 16. Optical appliances;
- 17. Hearing aid services;
- 18. Home health agency services, except that home health agency services for aged, blind and disabled (ABD) beneficiaries are covered fee-for-service and not by the MCO;
- 19. Hospice services, in the community and in institutional settings. Room and board services are included only when services are delivered in an institutional (non-private residence) setting;
- 20. Durable medical equipment (DME)/assistive technology devices in accordance with existing Medicaid rules (see N.J.A.C. 10:59);
- 21. Medical supplies;
- 22. Prosthetics and orthotics, including certified shoe provider services;
- 23. Dental services;
- 24. Organ transplants, which include donor and recipient costs, except that the Medicaid fee-for-service program will reimburse for transplant-related donor and recipient inpatient hospital costs for an individual placed on a

transplant list while in the fee-for-service Medicaid program prior to initial enrollment into an MCO;

25. Transportation services to and from any MCO-covered service and any service covered by the fee-for-service program as specified in this chapter, including ambulance, mobile intensive care units (MICUs) and mobile assistive vehicles (MAVs) (including lift-equipped vehicles);

26. Nursing Facility Services – limited to first 30 days of admission to a nursing facility. This covered benefit is limited to rehabilitation services for NJ FamilyCare – Plan B and C enrollees; and

27. Mental health/substance abuse services only for enrollees who are clients of the Division of Developmental Disabilities. Partial care and partial hospitalization services are covered fee-for-service and are not covered by the MCO.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.3 recodified as N.J.A.C. 10:74-3.12; section was "General Medicaid and NJ KidCare program limitations".

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Rewrote the introductory paragraph of (a), and (a)1, (a)7, (a)9, (a)20, (a)26 and (a)27.

10:74-3.4 Fee-for-service program services requiring MCO assistance to Medicaid and NJ FamilyCare-Plans A, B and C enrollees to access the services

(a) The following services shall be provided to Plans A, B and C enrollees through the Medicaid/NJ FamilyCare fee-for-service program and may necessitate contractor assistance to the enrollee (such as medical orders) to access the services:

- 1. Personal care assistant services (not covered for NJ FamilyCare-Plans B and C);
- 2. Medical day care (not covered for NJ FamilyCare-Plans B and C);
- 3. Outpatient rehabilitation services, including physical, occupational and speech/language therapy (for Plans B and C, limited to 60 days per therapy per calendar year);
- 4. Elective/induced abortions and related services, including surgical procedure, cervical dilation, insertion of cervical dilator, anesthesia including para cervical block, history and physical exam on day of surgery; PT, PTT, OB panel of lab tests, pregnancy test, urinalysis and urine drug screen, glucose and electrolytes; routine venipuncture, ultrasound, pathological examination of aborted fetus; Rhogam and its administration;
- 5. Transportation, lower mode (not covered for NJ FamilyCare-Plans B and C);
- 6. Sex abuse examinations;

7. Services provided by DHS mental health/substance abuse and DYFS residential facilities or group homes;

8. Family planning services and supplies when furnished by a non-MCO-participating provider;

9. Home health agency services for the aged, blind and disabled; and

10. Prescription drugs (legend and non-legend covered by the Medicaid program) for the aged, blind or disabled.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.4 recodified as N.J.A.C. 10:74-3.13; section was "General Medicaid and NJ KidCare program exclusions".

10:74-3.5 Fee-for-service services for Medicaid and NJ FamilyCare-Plans A, B and C enrollees not requiring case management by the MCO

(a) The following services shall be provided to Plans A, B and C enrollees through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO:

1. Inpatient psychiatric hospital services for individuals under 21 and for individuals 65 years of age and over;

2. ICF/MR services (not covered for NJ FamilyCare-Plans B and C);

3. Waiver and demonstration program services (not covered for NJ FamilyCare-Plans B and C);

4. Mental health services for non-DDD clients;

5. Substance abuse services for non-DDD clients:

- i. Diagnosis;
- ii. Treatment; and
- iii. Detoxification;

6. Drugs paid fee-for-service by the Medicaid program:

- i. Costs for methadone maintenance and its administration;
- ii. Atypical antipsychotic drugs;
- iii. Suboxone and Subutex or any other drug within this category when used for the treatment of opioid dependence; and
- iv. Generically-equivalent drug products of the drugs listed above.

7. Family planning services and supplies when furnished by a non-MCO-participating provider;

8. Up to 12 inpatient hospital days for social necessity (not covered for NJ FamilyCare-Plans B and C); and

9. Division of Developmental Disabilities Community Care Waiver (DDD/CCW) waiver services and demon-

stration program services. These are covered for NJ FamilyCare-Plan A enrollees only.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.5 recodified as N.J.A.C. 10:74-3.14; section was "Reporting of services".

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Deleted (a)1 and (a)2; recodified (a)3 through (a)11 as (a)1 through (a)9; in (a)6i, deleted "and" from the end; added (a)6iii and (a)6iv; and rewrote (a)9.

10:74-3.6 Managed care organization (MCO) services for NJ FamilyCare-Plan D enrollees

(a) The MCO shall provide all services required by the current managed care contract, including, but not limited to, the services listed in (a)1 through 22 below, and at N.J.A.C. 10:49-5, for all NJ FamilyCare-Plan D enrollees with the exception of those services identified as fee-for-service under N.J.A.C. 10:74-3.7 or excluded under N.J.A.C. 10:74-3.8:

1. Primary care services as follows:

i. All physician services, primary and specialty;

ii. In accordance with State certification/licensure requirements, standards, and practices, primary care providers shall also include access to certified nurse midwives, advanced practice nurses and physician assistants;

iii. Services rendered at independent clinics that provide ambulatory services; and

iv. Federally qualified health center primary care services;

2. Emergency room services;

3. Family planning services, including medical history and physical examinations (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling, except that:

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be covered by the NJ FamilyCare program; and

ii. Family planning services from providers outside the contractor's provider network shall not be available to NJ FamilyCare-Plan D enrollees, except for those Plan D enrollees with incomes below 134 percent of the FPL;

4. Home health care services, which shall be limited to:

i. Skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse;

- ii. Home health aide services when the purpose of the treatment is skilled care; and
- iii. Medical social services which are necessary for the treatment of the beneficiary's medical condition;
- 5. Hospice services;
- 6. Inpatient hospital services, including general hospitals, special hospitals, and rehabilitation hospitals. The MCO shall not be responsible when the primary admitting diagnosis is mental health or substance abuse related;
- 7. Outpatient hospital services, including outpatient surgery, but excluding mental health visits;
- 8. Laboratory services, as follows:
 - i. All laboratory testing sites providing services shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number, pursuant to 42 C.F.R. Part 493;
 - ii. Providers with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver; and
 - iii. Laboratories with certificates of registration may perform a full range of laboratory services;
- 9. Radiology services, diagnostic and therapeutic;
- 10. Optometrist services, including one routine eye examination per year;
- 11. Optical appliances, which shall be limited to one pair of glasses (or contact lenses) per 24-month period or as medically necessary;
- 12. Organ transplant services which are non-experimental or non-investigational;
- 13. Prescription drugs, excluding over-the-counter drugs, except that protease inhibitors and other antiretrovirals shall be furnished fee-for-service or through the AIDS Drug Distribution Program (ADDP);
- 14. Dental services for children under the age of 19 years, which shall be limited to preventive dental services, and which shall include oral examinations, x-rays, oral prophylaxis and topical application of fluorides and sealants, except that:
 - i. Comprehensive orthodontia treatment services shall be provided, through completion of required services, for any enrollee under the age of 19 years whose orthodontia services were initiated while enrolled with the MCO as a Medicaid, NJ FamilyCare-Plans A, B, or C enrollee;
 - ii. The MCO shall not be responsible for orthodontia services to a Plan D enrollee under the age of 19 years that were initiated while that individual was enrolled with another MCO;

- iii. The Plan D enrollee shall continue enrollment in the MCO where services were initiated until those services are completed or until the member loses Medicaid/NJ FamilyCare eligibility; and
- iv. Initiation of active treatment for orthodontia services begins with the placement of the orthodontic appliances (banding). If banding has not occurred, the services shall not qualify for continuation of care;
- 15. Podiatrist services, excluding routine hygienic care of the feet, such as the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition;
- 16. Prosthetic appliances, which shall be limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect. Repair and replacement services shall be covered when due to congenital growth;
- 17. Private duty nursing, only when authorized by the MCO;
- 18. Transportation services, which shall be limited to ambulance for medical emergency only;
- 19. Well child care, including immunizations and lead screening/treatments;
- 20. Maternity and related newborn care;
- 21. Diabetic supplies and equipment;
- 22. Audiology and hearing aid services - limited to children under the age of 16 years; and
- 23. Durable medical equipment - limited benefit, as required under the managed care contract.

New Rule, R.2006 d.17, effective January 3, 2006.
 See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
 Former N.J.A.C. 10:74-3.6 recodified as N.J.A.C. 10:74-3.15; section was "Availability of services".
 Amended by R.2012 d.041, effective February 21, 2012.
 See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).
 Rewrote the introductory paragraph of (a); in (a)7, inserted ", but excluding mental health visits"; in the introductory paragraph of (a)14, substituted "19" for "12"; in (a)20, deleted "and" from the end; in (a)21, substituted a semicolon for a period at the end; and added (a)22 and (a)23.

10:74-3.7 Fee-for-service benefits for NJ FamilyCare-Plan D enrollees

- (a) The following services shall be available to NJ FamilyCare-Plan D enrollees under fee-for-service:
- 1. Abortion services;
 - 2. Outpatient rehabilitation services, which shall include physical therapy, occupational therapy, and speech therapy, limited to 60 business days per incident of illness or injury beginning with the first day of treatment per contract year. Speech therapy services rendered for treat-

ment of delays in speech development, unless resulting from disease, injury or congenital disease, are not covered;

3. Mental health services, as follows:

i. Inpatient hospital services for mental health, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention, or home health mental health services, limited to 20 visits per year;

iii. When authorized by the Division of Medical Assistance and Health Services, one mental health inpatient day may be exchanged for up to four home health visits or four outpatient services, including partial care, up to a maximum of 10 inpatient days, for a maximum of 40 additional outpatient visits;

iv. When authorized by the Division of Medical Assistance and Health Services, one mental health inpatient day may be exchanged for two days of treatment in partial hospitalization, up to the maximum number of covered inpatient days; and

v. There is no limit to the number of days or visits as indicated in (a)3i through iv above, for CHIP beneficiaries under the age of 19 pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008; and

4. Inpatient and outpatient services for substance abuse, which shall be limited to detoxification. There is no service limit for CHIP beneficiaries under the age of 19 pursuant to the MHPAEA of 2008.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.7 recodified as N.J.A.C. 10:74-1.5; section was "Pharmacy lock-in program under managed care".

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

In the introductory paragraph of (a)3, inserted a comma following "services"; added (a)3v; and in (a)4, inserted the last sentence.

10:74-3.8 Benefits not provided for NJ FamilyCare-Plan D enrollees

(a) The following services shall not be covered for NJ FamilyCare-Plan D participants either by the MCO or the Department:

1. Services that are not medically necessary services;
2. Intermediate care facility services for the mentally retarded (ICF/MR);
3. Private duty nursing, unless authorized by the MCO;
4. Personal care assistant services;
5. Medical day care services;
6. Chiropractic services;

7. Dental services, except that preventive dentistry for children under the age of 19 shall be provided;

8. Orthotic devices;

9. Residential treatment center psychiatric programs;

10. Religious non-medical institutions care and services;

11. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, with the exception of well child care, including immunizations and lead screening/treatments;

12. Transportation services, including non-emergency ambulance, invalid coach, and lower mode transportation;

13. Blood and blood plasma, except that administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered;

14. Cosmetic services;

15. Custodial care;

16. Special remedial and educational services;

17. Experimental and investigational services;

18. Medical supplies, with the exception of diabetic supplies;

19. Infertility services;

20. Rehabilitative services for substance abuse;

21. Weight reduction programs or dietary supplements, except for surgical procedures or other procedures for treatment of obesity, when approved by the MCO;

22. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

23. Temporomandibular joint disorder treatment, including treatment performed by prosthesis placed directly in the teeth;

24. Recreational therapy;

25. Sleep therapy;

26. Court-ordered services;

27. Thermograms and thermography;

28. Biofeedback;

29. Radial keratotomy;

30. Respite care;

31. Nursing facility services; and

32. Audiologist and hearing aid services except for children under 16 years.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Amended by R.2012 d.041, effective February 21, 2012.
See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

In (a)7, substituted "19" for "12"; deleted (a)9, (a)12, and (a)15; recodified (a)10 and (a)11 as (a)9 and (a)10, (a)13 and (a)14 as (a)11 and (a)12, and (a)16 through (a)34 as (a)13 through (a)31; in (a)30, deleted "and" from the end; in (a)31, substituted "Nursing" for "Skilled nursing" and "; and" for a period at the end; and added (a)32.

10:74-3.9 General Medicaid and NJ FamilyCare program limitations

(a) The following service requirements and limitations shall apply in the standard service package or capitation payments, even if provided by the MCO:

1. Although services of podiatrists shall be provided, New Jersey Medicaid does not ordinarily cover routine foot care or treatment of flat foot conditions. These services shall be provided only when medical necessity is determined.
2. Occupational therapy and treatment for speech, language or hearing disorders shall be covered only when provided to an enrollee by a nursing facility, an approved home health agency, a hospital inpatient and outpatient department or an independent outpatient clinic.

3. Elective/induced abortions are not covered under an MCO program but will continue to be paid on a fee-for-service basis by the Medicaid and NJ FamilyCare program.

The following annotation applies to N.J.A.C. 10:74-3.9 prior to its repeal by R.2012 d.041:

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

The following annotations apply to N.J.A.C. 10:74-3.9 subsequent to its recodification from N.J.A.C. 10:74-3.12 by R.2012 d.041:

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

In (a)4, inserted a reference to NJ KidCare.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.
Recodified from N.J.A.C. 10:74-3.3 and amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Deleted provisions regarding physical therapists; section was "General Medicaid and NJ KidCare program limitations".
Recodified from N.J.A.C. 10:74-3.12 by R.2012 d.041, effective February 21, 2012.
See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Former N.J.A.C. 10:74-3.9, Managed care organization (MCO) services for NJ FamilyCare-Plan H enrollees, was repealed.

10:74-3.10 General Medicaid and NJ FamilyCare program exclusions

(a) The following shall not be considered covered services in the capitation rate, if provided:

1. All claims arising directly or indirectly from services provided by or in institutions owned or operated by the Federal government;
2. Elective cosmetic surgery;

3. Rest cures;

4. Personal comfort and convenience items; services and supplies not directly related to the care of the patient, including, but not limited to, guest meals and accommodations, telephone charges, travel expenses other than those services which may be specifically covered under the standard benefits package (such as ambulance services), take-home supplies and similar costs;

5. Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey and regulations issued pursuant thereto;

6. Infertility treatment services;

7. Services provided in an inpatient psychiatric institution that is not an acute care hospital to individuals under 65 years of age and over 21 years of age; and

8. Private duty nursing in an institution or hospital setting and private duty nursing provided in any setting for individuals 21 years of age or older.

The following annotation applies to N.J.A.C. 10:74-3.10 prior to its repeal by R.2012 d.041:

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

The following annotations apply to N.J.A.C. 10:74-3.10 subsequent to its recodification from N.J.A.C. 10:74-3.13 by R.2012 d.041:

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.
Recodified from N.J.A.C. 10:74-3.4 and amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Section was "General Medicaid and NJ KidCare program exclusions".
Recodified from N.J.A.C. 10:74-3.13 by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).
Former N.J.A.C. 10:74-3.10, Fee-for-service benefits for NJ FamilyCare-Plan H enrollees, was repealed.

10:74-3.11 Reporting and verification of services

All services, including, but not limited to, those listed in N.J.A.C. 10:74-3.9 and 3.10, shall be reported on encounters despite the limitations or exclusions, and the contractor shall document and verify that the services were provided.

The following annotation applies to N.J.A.C. 10:74-3.11 prior to its repeal by R.2012 d.041:

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

The following annotations apply to N.J.A.C. 10:74-3.11 subsequent to its recodification from N.J.A.C. 10:74-3.14 by R.2012 d.041:

Recodified from N.J.A.C. 10:74-3.5 and amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Updated N.J.A.C. references.
Recodified from N.J.A.C. 10:74-3.14 and amended by R.2012 d.041, effective February 21, 2012.
See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Section was "Reporting of services". Rewrote the section. Former N.J.A.C. 10:74-3.11, Benefits not provided for NJ FamilyCare-Plan H enrollees, was repealed.

10:74-3.12 Availability of services

(a) Each contractor shall demonstrate the availability and accessibility of institutional facilities and professional, allied and supporting paramedical personnel to perform the agreed-upon services.

(b) Each contractor shall ensure that no distinctions will be made with regard to quality of service or availability of covered benefits between Medicaid and NJ FamilyCare enrollees under this subchapter and any other parties served by the contractor.

(c) Each Medicaid and NJ FamilyCare enrollee shall be given the choice of a primary care provider who will supervise and coordinate his or her care.

(d) Generally, the contractor shall have only one enrollment area for all Medicaid or NJ FamilyCare parties served, including those served under these regulations. Modifications of such enrollment area for purposes of contracting under this subchapter shall be achieved by means of contract amendment.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Inserted references to NJ KidCare throughout.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Recodified from N.J.A.C. 10:74-3.6 and amended by R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from N.J.A.C. 10:74-3.15 by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Former N.J.A.C. 10:74-3.12, General Medicaid and NJ FamilyCare program limitations, was recodified to N.J.A.C. 10:74-3.9.

10:74-3.13 (Reserved)

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Recodified from N.J.A.C. 10:74-3.4 and amended by R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Section was "General Medicaid and NJ KidCare program exclusions".

Recodified from N.J.A.C. 10:74-3.10 by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Section was "General Medicaid and NJ FamilyCare program exclusions".

10:74-3.14 (Reserved)

Recodified from N.J.A.C. 10:74-3.5 and amended by R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Updated N.J.A.C. references.

Recodified to N.J.A.C. 10:74-3.11 by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Section was "Reporting of services".

10:74-3.15 (Reserved)

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Inserted references to NJ KidCare throughout.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Recodified from N.J.A.C. 10:74-3.6 and amended by R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Substituted "FamilyCare" for "KidCare" throughout.

Recodified to N.J.A.C. 10:74-3.12 by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Section was "Availability of services".

SUBCHAPTER 4. MARKETING

10:74-4.1 Marketing

(a) The contractor shall obtain written approval from the Division prior to the commencement of marketing activities, regarding the form and content of the following:

1. Informational and instructional materials to be distributed to inform Medicaid and NJ FamilyCare enrollees of the scope and nature of benefits provided by the contractor;

2. Informational and instructional materials to be distributed to inform Medicaid and NJ FamilyCare enrollees of changes in program scope or administration;

3. Public information releases pertaining to the enrollment of Medicaid and NJ FamilyCare individuals in the contractor's plan; and

4. Instruction to community-based organizations that will empower them to provide instruction to their beneficiaries to achieve better health outcomes.

(b) The contractor shall ensure that:

1. All of the contractor's marketing presentations accurately and clearly represent the benefits and limitations of the contractor's plan, and are not false or misleading in any way;

2. All of the contractor's marketing representatives and agents have received sufficient instructions and training to be capable of performing such marketing activities;

3. All of the contractor's marketing representatives represent themselves as agents of the contractor involved in marketing;