



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 17 No. 10

May 2007

TO: All Providers

SUBJECT: Discontinuance of NJ FamilyCare (NJFC) Plan "H"

EFFECTIVE: Service dates on or after July 1, 2007

PURPOSE: To notify all providers that, effective for services rendered on or after July 1, 2007, NJFC Plan H will be discontinued and all Plan H beneficiaries will be covered by Plan D

BACKGROUND: NJ FamilyCare (NJFC) Plan H currently provides certain adults without dependent children with most health care benefits through health maintenance organizations (HMOs) under contract with the New Jersey Department of Human Services. Restricted alien parents also receive health care benefits provided by HMOs participating in NJ FamilyCare. Plan H will be discontinued on July 1, 2007 and Plan H beneficiaries will be covered by Plan D thereafter. No beneficiary action will be required to effect the change.

ACTION: Effective for service dates on or after July 1, 2007, the individuals covered under Plan H, including restricted alien parents, will be transferred to and covered by NJ FamilyCare Plan D.

The list of Plan D covered benefits is attached to this Newsletter.

Providers must continue to verify eligibility before they provide services, using REVS, MEVS, eMEVS or POS.

Please note that NJ FamilyCare remains available to all eligible children with annual family incomes up to 350% of the FPL. Also, Presumptive Eligibility is still an option for children in families with income at or below 350% FPL and for pregnant women with income at or below 200% FPL.

If there are any questions concerning this Newsletter, please call the NJ FamilyCare/Medicaid program's Medical Assistance Customer Center (MACC) in your area. (See the attached list of MACC offices.)

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")**

**COVERED HEALTH CARE SERVICES
UNDER NJ FAMILYCARE PLAN D**

Service Type	HMO Benefit (unless otherwise indicated)
Abortion	YES OUT-OF-PLAN BENEFIT
AIDS Drug Distribution Program (ADDP) Participation	Plan D beneficiaries must enroll in the ADDP to receive HIV prescription drugs
Ambulance – Emergency	YES
Ambulatory Surgery	YES
Certified Nurse Practitioner/Clinical Nurse Specialist (Non-Maternity)	YES (\$5 COPAY EXCEPT FOR PREVENTIVE SERVICES. \$10 COPAY FOR NON-OFFICE HOURS & HOME VISITS MAY BE CHARGED BASED ON INCOME)
Clinic Services (free standing) – Ambulatory	YES (\$5 COPAY MAY BE CHARGED BASED ON INCOME)
Clinic Services (free standing) – Mental Health	YES (\$5 COPAY MAY BE CHARGED BASED ON INCOME) Note: Out-of-plan community-based mental health services are limited to twenty (20) service days per calendar year and are eligible for payment as fee-for-service.
Diabetic supplies and equipment	YES
Emergency Room	YES (\$35 COPAY MAY BE CHARGED BASED ON INCOME)
Family Planning Services	YES
Federally Qualified Health Centers (FQHC) Primary Care Services	YES
Home Health Care Services	YES (limited to skilled nursing for homebound member)
Hospice Services	YES
Inpatient Hospital – NOT related to mental health (MH) or substance abuse (SA)	YES
Inpatient Hospital – related to MH/SA	YES (35 days per year for MH; detoxification only for SA)
Laboratory Services	YES (\$5 COPAY MAY BE CHARGED BASED ON INCOME)
Maternity and related newborn care	YES
Optometrist Services	YES (includes one routine eye exam per year, with \$5.00 copay)
Optical Appliances	YES (limited to one pair of glasses per 24 months)
Organ Transplants	YES
Outpatient Hospital – NOT related to MH/SA FFS	YES (\$5.00 copay except for preventive services)
Outpatient Hospital – related to MH/SA FFS	YES (\$25.00 copay for MH, \$5.00 copay for SA, 20 visits per year)
Outpatient Rehabilitation Services FFS	YES (\$5.00 copay for physical therapy, occupational therapy, speech therapy)
Physician Services	YES (\$5 COPAY EXCEPT FOR PREVENTIVE SERVICES; \$10 COPAY FOR NON-OFFICE HOURS & HOME VISITS MAY BE CHARGED BASED ON INCOME)
Podiatry Services Note: Routine Services are not covered.	YES (\$5.00 copay)
Prescription Drugs, other than Atypical Antipsychotic drugs and Antiretrovirals Note: Over-the Counter Drugs are not covered.	YES (\$5 COPAY/\$10 COPAY FOR GREATER THAN 34-DAY SUPPLY MAY BE CHARGED BASED ON INCOME)
Prescription Drugs -Atypical Antipsychotic Drugs and Antiretrovirals	YES OUT-OF-PLAN BENEFIT
Private Duty Nursing	YES (only when authorized by the HMO)
Prosthetic Appliances	YES (limited to replacement of body part due to loss or impairment as a result of disease, injury or congenital defect)
Radiological Services (Diagnostic and Therapeutic)	YES (\$5 COPAY MAY BE CHARGED BASED ON INCOME)

MEDICAL ASSISTANCE CUSTOMER CENTERS

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- Denotes Home Office