

P.L. 2025, CHAPTER 283, *approved January 18, 2026*
Senate Committee Substitute for
Senate, Nos. 4894 and 4726

1 AN ACT concerning insurance and State Medicaid coverage for
2 immunizations and the Advisory Committee on Immunization
3 Practices and amending various parts of the statutory law.
4

5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7

8 1. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to
9 read as follows:

10 2. No hospital service corporation contract providing hospital
11 or medical expense benefits for groups with greater than 50 persons
12 shall be delivered, issued, executed, or renewed in this State, or
13 approved for issuance or renewal in this State by the Commissioner
14 of Banking and Insurance on or after the effective date of P.L.2005,
15 c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits
16 to any named subscriber or other person covered thereunder for
17 expenses incurred in the following:

18 a. Screening by blood lead measurement for lead poisoning for
19 children, including confirmatory blood lead testing as specified by
20 the Department of Health pursuant to section 7 of P.L.1995, c.316
21 (C.26:2-137.1); and medical evaluation and any necessary medical
22 follow-up and treatment for lead poisoned children.

23 b. All childhood immunizations as recommended by the
24 **[Advisory Committee on Immunization Practices of the United**
25 **States Public Health Service and the]** Department of Health
26 **[pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)],** which
27 shall consider the recommendations of the Advisory Committee on
28 Immunization Practices of the Centers for Disease Control and
29 Prevention in the federal Department of Health and Human Services
30 and, as appropriate, the recommendations of the American
31 Academy of Pediatrics, the American Academy of Family
32 Physicians, the American College of Obstetricians and
33 Gynecologists, and the American College of Physicians. A hospital
34 service corporation shall notify its subscribers, in writing, of any
35 change in coverage with respect to childhood immunizations and
36 any related changes in premium. Such notification shall be in a
37 form and manner to be determined by the Commissioner of Banking
38 and Insurance.

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 c. Screening for newborn hearing loss by appropriate
2 electrophysiologic screening measures and periodic monitoring of
3 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
4 (C.26:2-103.1 et al.). Payment for this screening service shall be
5 separate and distinct from payment for routine new baby care in the
6 form of a newborn hearing screening fee as negotiated with the
7 provider and facility.

8 The benefits provided pursuant to this section shall be provided
9 to the same extent as for any other medical condition under the
10 contract, except that a deductible shall not be applied for benefits
11 provided pursuant to this section; however, with respect to a
12 contract that qualifies as a high deductible health plan for which
13 qualified medical expenses are paid using a health savings account
14 established pursuant to section 223 of the federal Internal Revenue
15 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied
16 for any benefits provided pursuant to this section which represent
17 preventive care as permitted by that federal law, and shall not be
18 applied as provided pursuant to section 6 of P.L.2005, c.248
19 (C.17:48-6dd). This section shall apply to all hospital service
20 corporation contracts in which the health service corporation has
21 reserved the right to change the premium.

22 (cf: P.L.2012, c.17, s.35)

23
24 2. Section 1 of P.L.2019, c.360 (C.17:48-6tt) is amended to
25 read as follows:

26 1. a. A hospital service corporation contract that provides
27 hospital or medical expense benefits and is delivered, issued,
28 executed or renewed in this State, or approved for issuance or
29 renewal in this State by the Commissioner of Banking and
30 Insurance, on or after the effective date of this act, shall provide
31 coverage, without requiring any cost sharing, for the following
32 preventive services:

33 (1) evidence-based items or services that have in effect a rating
34 of "A" or "B" in the current recommendations of the United States
35 Preventive Services Task Force;

36 (2) immunizations that have in effect a recommendation from
37 the [Advisory Committee on Immunization Practices of the Centers
38 for Disease Control and Prevention] Department of Health, which
39 shall in making its recommendations consider the recommendations
40 of the Advisory Committee on Immunization Practices of the
41 Centers for Disease Control and Prevention in the federal
42 Department of Health and Human Services and, as appropriate, the
43 recommendations of the American Academy of Pediatrics, the
44 American Academy of Family Physicians, the American College of
45 Obstetricians and Gynecologists, and the American College of
46 Physicians;

47 (3) with respect to infants, children, and adolescents, evidence-
48 informed preventive care and screenings provided for in the

1 comprehensive guidelines supported by the Health Resources and
2 Services Administration; and

3 (4) with respect to women, any additional preventive care and
4 screenings not described in paragraph (1) as provided for in the
5 comprehensive guidelines supported by the Health Resources and
6 Services Administration.

7 b. (1) Except as provided in paragraph (2) of this subsection,
8 nothing in this section shall:

9 (a) require a contract which has a network of providers to
10 provide benefits for items or services described in subsection a. of
11 this section that are delivered by an out-of-network provider; or

12 (b) preclude a contract which has a network of providers from
13 imposing cost-sharing requirements for items or services described
14 in subsection a. of this section that are delivered by an out-of-
15 network provider.

16 (2) If a contract does not have in its network a provider who can
17 provide an item or service described in subsection a. of this section,
18 the contract shall cover the item or service when performed by an
19 out-of-network provider, and shall not impose cost sharing with
20 respect to that item or service.

21 c. (1) A contract shall provide coverage for an item or service
22 described in subsection a. of this section for plan years that begin
23 on or after the date that is one year after the date the
24 recommendation or guideline is issued.

25 (2) (a) Except as provided in subparagraph (b) of this paragraph,
26 a contract that is required to provide coverage for an item or service
27 described in subsection a. of this section on the first day of a plan
28 year shall provide coverage for that item or service through the last
29 day of the plan year.

30 (b) The commissioner may remove a coverage requirement for
31 an item or service during a plan year if the recommendation or
32 guideline changes or is no longer described in subsection a. of this
33 section.

34 d. The provisions of this section shall apply to those hospital
35 service corporation contracts in which the hospital service
36 corporation has reserved the right to change the premium.

37 (cf: P.L.2019, c.360, s.1)

38
39 3. Section 3 of P.L.2019, c.360 (C.17:48E-35.44) is amended
40 to read as follows:

41 3. a. A health service corporation contract that provides hospital
42 or medical expense benefits and is delivered, issued, executed or
43 renewed in this State, or approved for issuance or renewal in this
44 State by the Commissioner of Banking and Insurance, on or after
45 the effective date of this act, shall provide coverage, without
46 requiring any cost sharing, for the following preventive services:

1 (1) evidence-based items or services that have in effect a rating
2 of "A" or "B" in the current recommendations of the United States
3 Preventive Services Task Force;

4 (2) immunizations that have in effect a recommendation from
5 the **【Advisory Committee on Immunization Practices of the Centers**
6 **for Disease Control and Prevention】** Department of Health, which
7 shall in making its recommendations consider the recommendations
8 of the Advisory Committee on Immunization Practices of the
9 Centers for Disease Control and Prevention in the federal
10 Department of Health and Human Services and, as appropriate, the
11 recommendations of the American Academy of Pediatrics, the
12 American Academy of Family Physicians, the American College of
13 Obstetricians and Gynecologists, and the American College of
14 Physicians;

15 (3) with respect to infants, children, and adolescents, evidence-
16 informed preventive care and screenings provided for in the
17 comprehensive guidelines supported by the Health Resources and
18 Services Administration; and

19 (4) with respect to women, any additional preventive care and
20 screenings not described in paragraph (1) as provided for in the
21 comprehensive guidelines supported by the Health Resources and
22 Services Administration.

23 b. (1) Except as provided in paragraph (2) of this subsection,
24 nothing in this section shall:

25 (a) require a contract which has a network of providers to
26 provide benefits for items or services described in subsection a. of
27 this section that are delivered by an out-of-network provider; or

28 (b) preclude a contract which has a network of providers from
29 imposing cost-sharing requirements for items or services described
30 in subsection a. of this section that are delivered by an out-of-
31 network provider.

32 (2) If a contract does not have in its network a provider who can
33 provide an item or service described in subsection a. of this section,
34 the contract shall cover the item or service when performed by an
35 out-of-network provider, and shall not impose cost sharing with
36 respect to that item or service.

37 c. (1) A contract shall provide coverage for an item or service
38 described in subsection a. of this section for plan years that begin
39 on or after the date that is one year after the date the
40 recommendation or guideline is issued.

41 (2) (a) Except as provided in subparagraph (b) of this paragraph,
42 a contract that is required to provide coverage for an item or service
43 described in subsection a. of this section on the first day of a plan
44 year shall provide coverage for that item or service through the last
45 day of the plan year.

46 (b) The commissioner may remove a coverage requirement for
47 an item or service during a plan year if the recommendation or

1 guideline changes or is no longer described in subsection a. of this
2 section.

3 d. The provisions of this section shall apply to those health
4 service corporation contracts in which the health service
5 corporation has reserved the right to change the premium.
6 (cf: P.L.2019, c.360, s.3)
7

8 4. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended
9 to read as follows:

10 1. No health service corporation contract providing hospital or
11 medical expense benefits for groups with greater than 50 persons
12 shall be delivered, issued, executed, or renewed in this State, or
13 approved for issuance or renewal in this State by the Commissioner
14 of Banking and Insurance on or after the effective date of P.L.2005,
15 c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits
16 to any named subscriber or other person covered thereunder for
17 expenses incurred in the following:

18 a. Screening by blood lead measurement for lead poisoning for
19 children, including confirmatory blood lead testing as specified by
20 the Department of Health pursuant to section 7 of P.L.1995, c.316
21 (C.26:2-137.1); and medical evaluation and any necessary medical
22 follow-up and treatment for lead poisoned children.

23 b. All childhood immunizations as recommended by the
24 **【Advisory Committee on Immunization Practices of the United**
25 **States Public Health Service and the】** Department of Health
26 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】, which**
27 **shall consider the recommendations of the Advisory Committee on**
28 **Immunization Practices of the Centers for Disease Control and**
29 **Prevention in the federal Department of Health and Human Services**
30 **and, as appropriate, the recommendations of the American**
31 **Academy of Pediatrics, the American Academy of Family**
32 **Physicians, the American College of Obstetricians and**
33 **Gynecologists, and the American College of Physicians.** A health
34 service corporation shall notify its subscribers, in writing, of any
35 change in coverage with respect to childhood immunizations and
36 any related changes in premium. The notification shall be in a form
37 and manner to be determined by the Commissioner of Banking and
38 Insurance.

39 c. Screening for newborn hearing loss by appropriate
40 electrophysiologic screening measures and periodic monitoring of
41 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
42 (C.26:2-103.1 et al.). Payment for this screening service shall be
43 separate and distinct from payment for routine new baby care in the
44 form of a newborn hearing screening fee as negotiated with the
45 provider and facility.

46 The benefits provided pursuant to this section shall be provided
47 to the same extent as for any other medical condition under the
48 contract, except that a deductible shall not be applied for benefits

1 provided pursuant to this section; however, with respect to a
2 contract that qualifies as a high deductible health plan for which
3 qualified medical expenses are paid using a health savings account
4 established pursuant to section 223 of the federal Internal Revenue
5 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied
6 for any benefits provided pursuant to this section which represent
7 preventive care as permitted by that federal law, and shall not be
8 applied as provided pursuant to section 3 of P.L.2005, c.248
9 (C.17:48E-35.28). This section shall apply to all health service
10 corporation contracts in which the health service corporation has
11 reserved the right to change the premium.
12 (cf: P.L.2012, c.17, s.38)

13

14 5. Section 2 of P.L.2019, c.360 (C.17:48A-7qq) is amended to
15 read as follows:

16 2. a. A medical service corporation contract that provides
17 hospital or medical expense benefits and is delivered, issued,
18 executed or renewed in this State, or approved for issuance or
19 renewal in this State by the Commissioner of Banking and
20 Insurance, on or after the effective date of this act, shall provide
21 coverage, without requiring any cost sharing, for the following
22 preventive services:

23 (1) evidence-based items or services that have in effect a rating
24 of "A" or "B" in the current recommendations of the United States
25 Preventive Services Task Force;

26 (2) immunizations that have in effect a recommendation from
27 the [Advisory Committee on Immunization Practices of the Centers
28 for Disease Control and Prevention] Department of Health, which
29 shall in making its recommendations consider the recommendations
30 of the Advisory Committee on Immunization Practices of the
31 Centers for Disease Control and Prevention in the federal
32 Department of Health and Human Services and, as appropriate, the
33 recommendations of the American Academy of Pediatrics, the
34 American Academy of Family Physicians, the American College of
35 Obstetricians and Gynecologists, and the American College of
36 Physicians;

37 (3) with respect to infants, children, and adolescents, evidence-
38 informed preventive care and screenings provided for in the
39 comprehensive guidelines supported by the Health Resources and
40 Services Administration; and

41 (4) with respect to women, any additional preventive care and
42 screenings not described in paragraph (1) as provided for in the
43 comprehensive guidelines supported by the Health Resources and
44 Services Administration.

45 b. (1) Except as provided in paragraph (2) of this subsection,
46 nothing in this section shall:

1 (a) require a contract which has a network of providers to
2 provide benefits for items or services described in subsection a. of
3 this section that are delivered by an out-of-network provider; or

4 (b) preclude a contract which has a network of providers from
5 imposing cost-sharing requirements for items or services described
6 in subsection a. of this section that are delivered by an out-of-
7 network provider.

8 (2) If a contract does not have in its network a provider who can
9 provide an item or service described in subsection a. of this section,
10 the contract shall cover the item or service when performed by an
11 out-of-network provider, and shall not impose cost sharing with
12 respect to that item or service.

13 c. (1) A contract shall provide coverage for an item or service
14 described in subsection a. of this section for plan years that begin
15 on or after the date that is one year after the date the
16 recommendation or guideline is issued.

17 (2) (a) Except as provided in subparagraph (b) of this paragraph,
18 a contract that is required to provide coverage for an item or service
19 described in subsection a. of this section on the first day of a plan
20 year shall provide coverage for that item or service through the last
21 day of the plan year.

22 (b) The commissioner may remove a coverage requirement for
23 an item or service during a plan year if the recommendation or
24 guideline changes or is no longer described in subsection a. of this
25 section.

26 d. The provisions of this section shall apply to those medical
27 service corporation contracts in which the medical service
28 corporation has reserved the right to change the premium.

29 (cf: P.L.2019, c.360, s.2)

30

31 6. Section 4 of P.L.2019, c.360 (C.17B:26-2.1mm) is amended
32 to read as follows:

33 4. a. An individual health insurer policy that provides hospital or
34 medical expense benefits and is delivered, issued, executed or
35 renewed in this State, or approved for issuance or renewal in this
36 State by the Commissioner of Banking and Insurance, on or after
37 the effective date of this act, shall provide coverage, without
38 requiring any cost sharing, for the following preventive services:

39 (1) evidence-based items or services that have in effect a rating
40 of "A" or "B" in the current recommendations of the United States
41 Preventive Services Task Force;

42 (2) immunizations that have in effect a recommendation from
43 the [Advisory Committee on Immunization Practices of the Centers
44 for Disease Control and Prevention] Department of Health, which
45 shall in making its recommendations consider the recommendations
46 of the Advisory Committee on Immunization Practices of the
47 Centers for Disease Control and Prevention in the federal
48 Department of Health and Human Services and, as appropriate, the

1 recommendations of the American Academy of Pediatrics, the
2 American Academy of Family Physicians, the American College of
3 Obstetricians and Gynecologists, and the American College of
4 Physicians;

5 (3) with respect to infants, children, and adolescents, evidence-
6 informed preventive care and screenings provided for in the
7 comprehensive guidelines supported by the Health Resources and
8 Services Administration; and

9 (4) with respect to women, any additional preventive care and
10 screenings not described in paragraph (1) as provided for in the
11 comprehensive guidelines supported by the Health Resources and
12 Services Administration.

13 b. (1) Except as provided in paragraph (2) of this subsection,
14 nothing in this section shall:

15 (a) require a policy which has a network of providers to provide
16 benefits for items or services described in subsection a. of this
17 section that are delivered by an out-of-network provider; or

18 (b) preclude a policy which has a network of providers from
19 imposing cost-sharing requirements for items or services described
20 in subsection a. of this section that are delivered by an out-of-
21 network provider.

22 (2) If a policy does not have in its network a provider who can
23 provide an item or service described in subsection a. of this section,
24 the policy shall cover the item or service when performed by an
25 out-of-network provider, and shall not impose cost sharing with
26 respect to that item or service.

27 c. (1) A policy shall provide coverage for an item or service
28 described in subsection a. of this section for plan years that begin
29 on or after the date that is one year after the date the
30 recommendation or guideline is issued.

31 (2) (a) Except as provided in subparagraph (b) of this paragraph,
32 a policy that is required to provide coverage for an item or service
33 described in subsection a. of this section on the first day of a plan
34 year shall provide coverage for that item or service through the last
35 day of the plan year.

36 (b) The commissioner may remove a coverage requirement for
37 an item or service during a plan year if the recommendation or
38 guideline changes or is no longer described in subsection a. of this
39 section.

40 d. This section shall apply to those policies in which the insurer
41 has reserved the right to change the premium.

42 (cf: P.L.2019, c.360, s.4)

43
44 7. Section 5 of P.L.2019, c.360 (C.17B:27-46.1tt) is amended
45 to read as follows:

46 5. a. A group health insurer policy that provides hospital or
47 medical expense benefits and is delivered, issued, executed or
48 renewed in this State, or approved for issuance or renewal in this

1 State by the Commissioner of Banking and Insurance, on or after
2 the effective date of this act, shall provide coverage, without
3 requiring any cost sharing, for the following preventive services:

4 (1) evidence-based items or services that have in effect a rating
5 of "A" or "B" in the current recommendations of the United States
6 Preventive Services Task Force;

7 (2) immunizations that have in effect a recommendation from
8 the [Advisory Committee on Immunization Practices of the Centers
9 for Disease Control and Prevention] Department of Health, which
10 shall in making its recommendations consider the recommendations
11 of the Advisory Committee on Immunization Practices of the
12 Centers for Disease Control and Prevention in the federal
13 Department of Health and Human Services and, as appropriate, the
14 recommendations of the American Academy of Pediatrics, the
15 American Academy of Family Physicians, the American College of
16 Obstetricians and Gynecologists, and the American College of
17 Physicians;

18 (3) with respect to infants, children, and adolescents, evidence-
19 informed preventive care and screenings provided for in the
20 comprehensive guidelines supported by the Health Resources and
21 Services Administration; and

22 (4) with respect to women, any additional preventive care and
23 screenings not described in paragraph (1) as provided for in the
24 comprehensive guidelines supported by the Health Resources and
25 Services Administration.

26 b. (1) Except as provided in paragraph (2) of this subsection,
27 nothing in this section shall:

28 (a) require a policy which has a network of providers to provide
29 benefits for items or services described in subsection a. of this
30 section that are delivered by an out-of-network provider; or

31 (b) preclude a policy which has a network of providers from
32 imposing cost-sharing requirements for items or services described
33 in subsection a. of this section that are delivered by an out-of-
34 network provider.

35 (2) If a policy does not have in its network a provider who can
36 provide an item or service described in subsection a. of this section,
37 the policy shall cover the item or service when performed by an
38 out-of-network provider, and shall not impose cost sharing with
39 respect to that item or service.

40 c. (1) A policy shall provide coverage for an item or service
41 described in subsection a. of this section for plan years that begin
42 on or after the date that is one year after the date the
43 recommendation or guideline is issued.

44 (2) (a) Except as provided in subparagraph (b) of this paragraph,
45 a policy that is required to provide coverage for an item or service
46 described in subsection a. of this section on the first day of a plan
47 year shall provide coverage for that item or service through the last
48 day of the plan year.

1 (b) The commissioner may remove a coverage requirement for
2 an item or service during a plan year if the recommendation or
3 guideline changes or is no longer described in subsection a. of this
4 section.

5 d. This section shall apply to those policies in which the insurer
6 has reserved the right to change the premium.

7 (cf: P.L.2019, c.360, s.5)

8
9 8. Section 3 of P.L.1995, c.316 (C.17B:27-46.11) is amended to
10 read as follows:

11 3. No group health insurance policy providing hospital or
12 medical expense benefits for groups with more than 50 persons
13 shall be delivered, issued, executed, or renewed in this State, or
14 approved for issuance or renewal in this State by the Commissioner
15 of Banking and Insurance on or after the effective date of P.L.2005,
16 c.248 (C.17:48E-35.27 et al.), unless the policy provides benefits to
17 any named insured or other person covered thereunder for expenses
18 incurred in the following:

19 a. Screening by blood lead measurement for lead poisoning for
20 children, including confirmatory blood lead testing as specified by
21 the Department of Health pursuant to section 7 of P.L.1995, c.316
22 (C.26:2-137.1); and medical evaluation and any necessary medical
23 follow-up and treatment for lead poisoned children.

24 b. All childhood immunizations as recommended by the
25 **【Advisory Committee on Immunization Practices of the United**
26 **States Public Health Service and the】** Department of Health
27 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】**, which
28 shall consider the recommendations of the Advisory Committee on
29 Immunization Practices of the Centers for Disease Control and
30 Prevention in the federal Department of Health and Human Services
31 and, as appropriate, the recommendations of the American
32 Academy of Pediatrics, the American Academy of Family
33 Physicians, the American College of Obstetricians and
34 Gynecologists, and the American College of Physicians. A health
35 insurer shall notify its policyholders, in writing, of any change in
36 coverage with respect to childhood immunizations and any related
37 changes in premium. Such notification shall be in a form and
38 manner to be determined by the Commissioner of Banking and
39 Insurance.

40 c. Screening for newborn hearing loss by appropriate
41 electrophysiologic screening measures and periodic monitoring of
42 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
43 (C.26:2-103.1 et al.). Payment for this screening service shall be
44 separate and distinct from payment for routine new baby care in the
45 form of a newborn hearing screening fee as negotiated with the
46 provider and facility.

47 The benefits provided pursuant to this section shall be provided
48 to the same extent as for any other medical condition under the

1 policy, except that a deductible shall not be applied for benefits
2 provided pursuant to this section; however, with respect to a policy
3 that qualifies as a high deductible health plan for which qualified
4 medical expenses are paid using a health savings account
5 established pursuant to section 223 of the federal Internal Revenue
6 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied
7 for any benefits provided pursuant to this section that represent
8 preventive care as permitted by that federal law, and shall not be
9 applied as provided pursuant to section 9 of P.L.2005, c.248
10 (C.17B:27-46.1dd). This section shall apply to all group health
11 insurance policies in which the health insurer has reserved the right
12 to change the premium.
13 (cf: P.L.2012, c.17, s.55)
14

15 9. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to
16 read as follows:

17 6. The commissioner shall approve the policy and contract
18 forms and benefit levels to be made available by all carriers for the
19 health benefits plans required to be issued pursuant to section 3 of
20 P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications
21 to one or more plans as the board determines are necessary to make
22 available a "high deductible health plan" or plans consistent with
23 section 301 of Title III of the "Health Insurance Portability and
24 Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220),
25 regarding tax-deductible medical savings accounts, within 60 days
26 after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The
27 commissioner shall provide the board with an informational filing
28 of the policy and contract forms and benefit levels it approves.

29 a. The individual health benefits plans established by the board
30 may include cost containment measures such as, but not limited to:
31 utilization review of health care services, including review of
32 medical necessity of hospital and physician services; case
33 management benefit alternatives; selective contracting with
34 hospitals, physicians, and other health care providers; and
35 reasonable benefit differentials applicable to participating and
36 nonparticipating providers; and other managed care provisions.

37 b. An individual health benefits plan offered pursuant to
38 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a
39 preexisting condition limitation of any period and shall not include
40 a preexisting condition as a factor in calculating the premium.

41 c. In addition to the standard individual health benefits plans
42 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the
43 board may develop up to five rider packages. Premium rates for the
44 rider packages shall be determined in accordance with section 8 of
45 P.L.1992, c.161 (C.17B:27A-9).

46 d. After the board's establishment of the individual health
47 benefits plans required pursuant to section 3 of P.L.1992, c.161
48 (C.17B:27A-4), and notwithstanding any law to the contrary, a

1 carrier shall file the policy or contract forms with the commissioner
2 and certify to the commissioner that the health benefits plans to be
3 used by the carrier are in substantial compliance with the provisions
4 in the corresponding approved plans. The certification shall be
5 signed by the chief executive officer of the carrier. Upon receipt by
6 the commissioner of the certification, the certified plans may be
7 used until the commissioner, after notice and hearing, disapproves
8 their continued use.

9 e. Effective immediately for an individual health benefits plan
10 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
11 35.27 et al.) and effective on the first 12-month anniversary date of
12 an individual health benefits plan in effect on the effective date of
13 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health
14 benefits plans required pursuant to section 3 of P.L.1992, c.161
15 (C.17B:27A-4), including any plan offered by a federally qualified
16 health maintenance organization, shall contain benefits for expenses
17 incurred in the following:

18 (1) Screening by blood lead measurement for lead poisoning for
19 children, including confirmatory blood lead testing as specified by
20 the Department of Health pursuant to section 7 of P.L.1995, c.316
21 (C.26:2-137.1); and medical evaluation and any necessary medical
22 follow-up and treatment for lead poisoned children.

23 (2) All childhood immunizations as recommended by the
24 **【Advisory Committee on Immunization Practices of the United**
25 **States Public Health Service and the】** Department of Health
26 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】**, which
27 shall consider the recommendations of the Advisory Committee on
28 Immunization Practices of the Centers for Disease Control and
29 Prevention in the federal Department of Health and Human Services
30 and, as appropriate, the recommendations of the American
31 Academy of Pediatrics, the American Academy of Family
32 Physicians, the American College of Obstetricians and
33 Gynecologists, and the American College of Physicians. A carrier
34 shall notify its insureds, in writing, of any change in the health care
35 services provided with respect to childhood immunizations and any
36 related changes in premium. Such notification shall be in a form
37 and manner to be determined by the Commissioner of Banking and
38 Insurance.

39 (3) Screening for newborn hearing loss by appropriate
40 electrophysiologic screening measures and periodic monitoring of
41 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
42 (C.26:2-103.1 et al.). Payment for this screening service shall be
43 separate and distinct from payment for routine new baby care in the
44 form of a newborn hearing screening fee as negotiated with the
45 provider and facility.

46 The benefits provided pursuant to this subsection shall be
47 provided to the same extent as for any other medical condition
48 under the health benefits plan, except that a deductible shall not be

1 applied for benefits provided pursuant to this subsection; however,
2 with respect to a health benefits plan that qualifies as a high
3 deductible health plan for which qualified medical expenses are
4 paid using a health savings account established pursuant to section
5 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),
6 a deductible shall not be applied for any benefits provided pursuant
7 to this subsection that represent preventive care as permitted by that
8 federal law, and shall not be applied as provided pursuant to section
9 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall
10 apply to all individual health benefits plans in which the carrier has
11 reserved the right to change the premium.

12 f. Effective immediately for a health benefits plan issued on or
13 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
14 effective on the first 12-month anniversary date of a health benefits
15 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
16 et al.), the health benefits plans required pursuant to section 3 of
17 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses
18 incurred in the purchase of prescription drugs shall provide benefits
19 for expenses incurred in the purchase of specialized non-standard
20 infant formulas, when the covered infant's physician has diagnosed
21 the infant as having multiple food protein intolerance and has
22 determined such formula to be medically necessary, and when the
23 covered infant has not been responsive to trials of standard non-cow
24 milk-based formulas, including soybean and goat milk. The
25 coverage may be subject to utilization review, including periodic
26 review, of the continued medical necessity of the specialized infant
27 formula.

28 The benefits shall be provided to the same extent as for any other
29 prescribed items under the health benefits plan.

30 This subsection shall apply to all individual health benefits plans
31 in which the carrier has reserved the right to change the premium.

32 g. Effective immediately for an individual health benefits plan
33 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
34 35.27 et al.) and effective on the first 12-month anniversary date of
35 an individual health benefits plan in effect on the effective date of
36 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
37 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)
38 that qualify as high deductible health plans for which qualified
39 medical expenses are paid using a health savings account
40 established pursuant to section 223 of the federal Internal Revenue
41 Code of 1986 (26 U.S.C. s.223), including any plan offered by a
42 federally qualified health maintenance organization, shall contain
43 benefits for expenses incurred in connection with any medically
44 necessary benefits provided in-network which represent preventive
45 care as permitted by that federal law.

46 The benefits provided pursuant to this subsection shall be
47 provided to the same extent as for any other medical condition
48 under the health benefits plan, except that a deductible shall not be

1 applied for benefits provided pursuant to this subsection. This
2 subsection shall apply to all individual health benefits plans in
3 which the carrier has reserved the right to change the premium.
4 (cf: P.L.2019, c.353, s.4)

5
6 10. Section 6 of P.L.2019, c.360 (C.17B:27A-7.27) is amended
7 to read as follows:

8 6. a. An individual health benefits plan that provides hospital
9 or medical expense benefits and is delivered, issued, executed or
10 renewed in this State, or approved for issuance or renewal in this
11 State by the Commissioner of Banking and Insurance, on or after
12 the effective date of this act, shall provide coverage, without
13 requiring any cost sharing, for the following preventive services:

14 (1) evidence-based items or services that have in effect a rating
15 of "A" or "B" in the current recommendations of the United States
16 Preventive Services Task Force;

17 (2) immunizations that have in effect a recommendation from
18 the [Advisory Committee on Immunization Practices of the Centers
19 for Disease Control and Prevention] Department of Health, which
20 shall in making its recommendations consider the recommendations
21 of the Advisory Committee on Immunization Practices of the
22 Centers for Disease Control and Prevention in the federal
23 Department of Health and Human Services and, as appropriate, the
24 recommendations of the American Academy of Pediatrics, the
25 American Academy of Family Physicians, the American College of
26 Obstetricians and Gynecologists, and the American College of
27 Physicians;

28 (3) with respect to infants, children, and adolescents, evidence-
29 informed preventive care and screenings provided for in the
30 comprehensive guidelines supported by the Health Resources and
31 Services Administration; and

32 (4) with respect to women, any additional preventive care and
33 screenings not described in paragraph (1) as provided for in the
34 comprehensive guidelines supported by the Health Resources and
35 Services Administration.

36 b. (1) Except as provided in paragraph (2) of this subsection,
37 nothing in this section shall:

38 (a) require a plan which has a network of providers to provide
39 benefits for items or services described in subsection a. of this
40 section that are delivered by an out-of-network provider; or

41 (b) preclude a plan which has a network of providers from
42 imposing cost-sharing requirements for items or services described
43 in subsection a. of this section that are delivered by an out-of-
44 network provider.

45 (2) If a plan does not have in its network a provider who can
46 provide an item or service described in subsection a. of this section,
47 the plan shall cover the item or service when performed by an out-

1 of-network provider, and shall not impose cost sharing with respect
2 to that item or service.

3 c. (1) A plan shall provide coverage for an item or service
4 described in subsection a. of this section for plan years that begin
5 on or after the date that is one year after the date the
6 recommendation or guideline is issued.

7 (2) (a) Except as provided in subparagraph (b) of this paragraph,
8 a plan that is required to provide coverage for an item or service
9 described in subsection a. of this section on the first day of a plan
10 year shall provide coverage for that item or service through the last
11 day of the plan year.

12 (b) The commissioner may remove a coverage requirement for
13 an item or service during a plan year if the recommendation or
14 guideline changes or is no longer described in subsection a. of this
15 section.

16 d. This section shall apply to all individual health benefits
17 plans in which the carrier has reserved the right to change the
18 premium.

19 (cf: P.L.2019, c.360, s.6)

20

21 11. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
22 read as follows:

23 3. a. Except as provided in subsection f. of this section, every
24 small employer carrier shall, as a condition of transacting business
25 in this State, offer to every small employer at least three of the
26 health benefit plans established by the board, as provided in this
27 section. The board shall establish a standard policy form for each
28 of the plans, which except as otherwise provided in subsection j. of
29 this section, shall be the only plans offered to small groups on or
30 after January 1, 1994. One policy form shall contain the benefits
31 provided for in sections 55, 57, and 59 of P.L.1991, c. 187
32 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of
33 indemnity carriers, one policy form shall be established which
34 contains benefits and cost sharing levels which are equivalent to the
35 health benefits plans of health maintenance organizations pursuant
36 to the "Health Maintenance Organization Act of 1973," Pub.L.93-
37 222 (42 U.S.C. s.300e et seq.). The remaining policy forms shall
38 contain basic hospital and medical-surgical benefits, including, but
39 not limited to:

40 (1) Basic inpatient and outpatient hospital care;

41 (2) Basic and extended medical-surgical benefits;

42 (3) Diagnostic tests, including X-rays;

43 (4) Maternity benefits, including prenatal and postnatal care; and

44 (5) Preventive medicine, including periodic physical
45 examinations and inoculations.

46 At least three of the forms shall provide for major medical
47 benefits in varying lifetime aggregates, one of which shall provide
48 at least \$1,000,000 in lifetime aggregate benefits. The policy forms

1 provided pursuant to this section shall contain benefits representing
2 progressively greater actuarial values.

3 Notwithstanding the provisions of this subsection to the contrary,
4 the board also may establish additional policy forms by which a
5 small employer carrier, other than a health maintenance
6 organization, may provide indemnity benefits or health maintenance
7 organization enrollees by direct contract with the enrollees' small
8 employer through a dual arrangement with the health maintenance
9 organization. The dual arrangement shall be filed with the
10 commissioner for approval. The additional policy forms shall be
11 consistent with the general requirements of P.L.1992, c.162
12 (C.17B:27A-17 et seq.).

13 b. Initially, a carrier shall offer a plan within 90 days of the
14 approval of such plan by the commissioner. Thereafter, the plans
15 shall be available to all small employers on a continuing basis.
16 Every small employer which elects to be covered under any health
17 benefits plan who pays the premium therefor and who satisfies the
18 participation requirements of the plan shall be issued a policy or
19 contract by the carrier.

20 c. The carrier may establish a premium payment plan which
21 provides installment payments and which may contain reasonable
22 provisions to ensure payment security, provided that provisions to
23 ensure payment security are uniformly applied.

24 d. In addition to the standard policies described in subsection a.
25 of this section, the board may develop up to five rider packages.
26 Any such package which a carrier chooses to offer shall be issued to
27 a small employer who pays the premium therefor, and shall be
28 subject to rating methodology set forth in section 9 of P.L.1992,
29 c.162 (C.17B:27A-25).

30 e. (Deleted by amendment, P.L.2008, c.38).

31 f. Notwithstanding the provisions of this section to the
32 contrary, a health maintenance organization which is a qualified
33 health maintenance organization pursuant to the "Health
34 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
35 s.300e et seq.) shall be permitted to offer health benefits plans
36 formulated by the board and approved by the commissioner which
37 are in accordance with the provisions of that law in lieu of the five
38 plans required pursuant to this section.

39 Notwithstanding the provisions of this section to the contrary, a
40 health maintenance organization which is approved pursuant to
41 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
42 benefits plans formulated by the board and approved by the
43 commissioner which are in accordance with the provisions of that
44 law in lieu of the plans required pursuant to this section, except that
45 the plans shall provide the same level of benefits as required for a
46 federally qualified health maintenance organization, including any
47 requirements concerning copayments by enrollees.

1 g. A carrier shall not be required to own or control a health
2 maintenance organization or otherwise affiliate with a health
3 maintenance organization in order to comply with the provisions of
4 this section, but the carrier shall be required to offer at least three of
5 the benefits plans which are formulated by the board and approved
6 by the commissioner, including one plan which contains benefits
7 and cost sharing levels that are equivalent to those required for
8 health maintenance organizations.

9 h. Notwithstanding the provisions of subsection a. of this
10 section to the contrary, the board may modify the benefits provided
11 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
12 17B:26B-2 and 26:2J-4.3).

13 i. (1) In addition to the rider packages provided for in subsection
14 d. of this section, every carrier may offer, in connection with the
15 health benefits plans required to be offered by this section, any
16 number of riders which may revise the coverage offered by the
17 plans in any way, provided, however, that any form of such rider or
18 amendment thereof which decreases benefits or decreases the
19 actuarial value of a plan shall be filed for informational purposes
20 with the board and for approval by the commissioner before such
21 rider may be sold. Any rider or amendment thereof which adds
22 benefits or increases the actuarial value of a plan shall be filed with
23 the board for informational purposes before such rider may be sold.
24 The added premium or reduction in premium for each rider, as
25 applicable, shall be listed separately from the premium for the
26 standard plan.

27 The commissioner shall disapprove any rider filed pursuant to
28 this subsection that is unjust, unfair, inequitable, unreasonably
29 discriminatory, misleading, contrary to law or the public policy of
30 this State. The commissioner shall not approve any rider which
31 reduces benefits below those required by sections 55, 57 and 59 of
32 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and
33 required to be sold pursuant to this section. The commissioner's
34 determination shall be in writing and shall be appealable.

35 (2) The benefit riders provided for in paragraph (1) of this
36 subsection shall be subject to the provisions of section 2, subsection
37 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162
38 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
39 24, 17B:27A-25, and 17B:27A-27).

40 j. (1) Notwithstanding the provisions of P.L.1992, c.162
41 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
42 by or through a carrier, association, or multiple employer
43 arrangement prior to January 1, 1994 or, if the requirements of
44 subparagraph (c) of paragraph (6) of this subsection are met, issued
45 by or through an out-of-State trust prior to January 1, 1994, at the
46 option of a small employer policy or contract holder, may be
47 renewed or continued after February 28, 1994, or in the case of such
48 a health benefits plan whose anniversary date occurred between

1 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
2 19.1 et al.), may be reinstated within 60 days of that anniversary
3 date and renewed or continued if, beginning on the first 12-month
4 anniversary date occurring on or after the sixtieth day after the
5 board adopts regulations concerning the implementation of the
6 rating factors permitted by section 9 of P.L.1992, c.162
7 (C.17B:27A-25) and, regardless of the situs of delivery of the health
8 benefits plan, the health benefits plan renewed, continued or
9 reinstated pursuant to this subsection complies with the provisions
10 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
11 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
12 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
13 section 7 of P.L.1995, c.340 (C17B:27A-19.3).

14 Nothing in this subsection shall be construed to require an
15 association, multiple employer arrangement or out-of-State trust to
16 provide health benefits coverage to small employers that are not
17 contemplated by the organizational documents, bylaws, or other
18 regulations governing the purpose and operation of the association,
19 multiple employer arrangement or out-of-State trust.
20 Notwithstanding the foregoing provision to the contrary, an
21 association, multiple employer arrangement or out-of-State trust
22 that offers health benefits coverage to its members' employees and
23 dependents:

24 (a) shall offer coverage to all eligible employees and their
25 dependents within the membership of the association, multiple
26 employer arrangement or out-of-State trust;

27 (b) shall not use actual or expected health status in determining
28 its membership; and

29 (c) shall make available to its small employer members at least
30 one of the standard benefits plans, as determined by the
31 commissioner, in addition to any health benefits plan permitted to
32 be renewed or continued pursuant to this subsection.

33 (2) Notwithstanding the provisions of this subsection to the
34 contrary, a carrier or out-of-State trust which writes the health
35 benefits plans required pursuant to subsection a. of this section shall
36 be required to offer those plans to any small employer, association
37 or multiple employer arrangement.

38 (3) (a) A carrier, association, multiple employer arrangement, or
39 out-of-State trust may withdraw a health benefits plan marketed to
40 small employers that was in effect on December 31, 1993 with the
41 approval of the commissioner. The commissioner shall approve a
42 request to withdraw a plan, consistent with regulations adopted by
43 the commissioner, only on the grounds that retention of the plan
44 would cause an unreasonable financial burden to the issuing carrier,
45 taking into account the rating provisions of section 9 of P.L.1992,
46 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
47 (C.17B:27A-19.3).

1 (b) A carrier which has renewed, continued or reinstated a health
2 benefits plan pursuant to this subsection that has not been newly
3 issued to a new small employer group since January 1, 1994, may,
4 upon approval of the commissioner, continue to establish its rates
5 for that plan based on the loss experience of that plan if the carrier
6 does not issue that health benefits plan to any new small employer
7 groups.

8 (4) (Deleted by amendment, P.L.1995, c.340).

9 (5) A health benefits plan that otherwise conforms to the
10 requirements of this subsection shall be deemed to be in compliance
11 with this subsection, notwithstanding any change in the plan's
12 deductible or copayment.

13 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)
14 of this paragraph, a health benefits plan renewed, continued or
15 reinstated pursuant to this subsection shall be filed with the
16 commissioner for informational purposes within 30 days after its
17 renewal date. No later than 60 days after the board adopts
18 regulations concerning the implementation of the rating factors
19 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing
20 shall be amended to show any modifications in the plan that are
21 necessary to comply with the provisions of this subsection. The
22 commissioner shall monitor compliance of any such plan with the
23 requirements of this subsection, except that the board shall enforce
24 the loss ratio requirements.

25 (b) A health benefits plan filed with the commissioner pursuant
26 to subparagraph (a) of this paragraph may be amended as to its
27 benefit structure if the amendment does not reduce the actuarial
28 value and benefits coverage of the health benefits plan below that of
29 the lowest standard health benefits plan established by the board
30 pursuant to subsection a. of this section. The amendment shall be
31 filed with the commissioner for approval pursuant to the terms of
32 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,
33 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as
34 applicable, and shall comply with the provisions of sections 2 and 9
35 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7
36 of P.L.1995, c.340 (C.17B:27A-19.3).

37 (c) A health benefits plan issued by a carrier through an out-of-
38 State trust shall be permitted to be renewed or continued pursuant to
39 paragraph (1) of this subsection upon approval by the commissioner
40 and only if the benefits offered under the plan are at least equal to
41 the actuarial value and benefits coverage of the lowest standard
42 health benefits plan established by the board pursuant to subsection
43 a. of this section. For the purposes of meeting the requirements of
44 this subparagraph, carriers shall be required to file with the
45 commissioner the health benefits plans issued through an out-of-
46 State trust no later than 180 days after the date of enactment of
47 P.L.1995, c.340. A health benefits plan issued by a carrier through
48 an out-of-State trust that is not filed with the commissioner pursuant

1 to this subparagraph, shall not be permitted to be continued or
2 renewed after the 180-day period.

3 (7) Notwithstanding the provisions of P.L.1992, c.162
4 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
5 employer arrangement or out-of-State trust may offer a health
6 benefits plan authorized to be renewed, continued or reinstated
7 pursuant to this subsection to small employer groups that are
8 otherwise eligible pursuant to paragraph (1) of subsection j. of this
9 section during the period for which such health benefits plan is
10 otherwise authorized to be renewed, continued or reinstated.

11 (8) Notwithstanding the provisions of P.L.1992, c.162
12 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,
13 multiple employer arrangement or out-of-State trust may offer
14 coverage under a health benefits plan authorized to be renewed,
15 continued or reinstated pursuant to this subsection to new
16 employees of small employer groups covered by the health benefits
17 plan in accordance with the provisions of paragraph (1) of this
18 subsection.

19 (9) Notwithstanding the provisions of P.L.1992, c.162
20 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to
21 the contrary, any individual, who is eligible for small employer
22 coverage under a policy issued, renewed, continued or reinstated
23 pursuant to this subsection, but who would be subject to a
24 preexisting condition exclusion under the small employer health
25 benefits plan, or who is a member of a small employer group who
26 has been denied coverage under the small employer group health
27 benefits plan for health reasons, may elect to purchase or continue
28 coverage under an individual health benefits plan until such time as
29 the group health benefits plan covering the small employer group of
30 which the individual is a member complies with the provisions of
31 P.L.1992, c.162 (C.17B:27A-17 et seq.).

32 (10) In a case in which an association made available a health
33 benefits plan on or before March 1, 1994 and subsequently changed
34 the issuing carrier between March 1, 1994 and the effective date of
35 P.L.1995, c.340, the new issuing carrier shall be deemed to have
36 been eligible to continue and renew the plan pursuant to paragraph
37 (1) of this subsection.

38 (11) In a case in which an association, multiple employer
39 arrangement or out-of-State trust made available a health benefits
40 plan on or before March 1, 1994 and subsequently changes the
41 issuing carrier for that plan after the effective date of P.L.1995,
42 c.340, the new issuing carrier shall file the health benefits plan with
43 the commissioner for approval in order to be deemed eligible to
44 continue and renew that plan pursuant to paragraph (1) of this
45 subsection.

46 (12) In a case in which a small employer purchased a health
47 benefits plan directly from a carrier on or before March 1, 1994 and
48 subsequently changes the issuing carrier for that plan after the

1 effective date of P.L.1995, c.340, the new issuing carrier shall file
2 the health benefits plan with the commissioner for approval in order
3 to be deemed eligible to continue and renew that plan pursuant to
4 paragraph (1) of this subsection.

5 Notwithstanding the provisions of subparagraph (b) of paragraph
6 (6) of this subsection to the contrary, a small employer who changes
7 its health benefits plan's issuing carrier pursuant to the provisions of
8 this paragraph, shall not, upon changing carriers, modify the benefit
9 structure of that health benefits plan within six months of the date
10 the issuing carrier was changed.

11 k. Effective immediately for a health benefits plan issued on or
12 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
13 and effective on the first 12-month anniversary date of a health
14 benefits plan in effect on the effective date of P.L.2005, c.248
15 (C.17:48E-35.27 et al.), the health benefits plans required pursuant
16 to this section, including any plans offered by a State approved or
17 federally qualified health maintenance organization, shall contain
18 benefits for expenses incurred in the following:

19 (1) Screening by blood lead measurement for lead poisoning for
20 children, including confirmatory blood lead testing as specified by
21 the Department of Health pursuant to section 7 of P.L.1995, c.316
22 (C.26:2-137.1); and medical evaluation and any necessary medical
23 follow-up and treatment for lead poisoned children.

24 (2) All childhood immunizations as recommended by the
25 **【Advisory Committee on Immunization Practices of the United**
26 **States Public Health Service and the】** Department of Health
27 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】**, which
28 shall consider the recommendations of the Advisory Committee on
29 Immunization Practices of the Centers for Disease Control and
30 Prevention in the federal Department of Health and Human Services
31 and, as appropriate, the recommendations of the American
32 Academy of Pediatrics, the American Academy of Family
33 Physicians, the American College of Obstetricians and
34 Gynecologists, and the American College of Physicians. A carrier
35 shall notify its insureds, in writing, of any change in the health care
36 services provided with respect to childhood immunizations and any
37 related changes in premium. Such notification shall be in a form
38 and manner to be determined by the Commissioner of Banking and
39 Insurance.

40 (3) Screening for newborn hearing loss by appropriate
41 electrophysiologic screening measures and periodic monitoring of
42 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
43 (C.26:2-103.1 et al.). Payment for this screening service shall be
44 separate and distinct from payment for routine new baby care in the
45 form of a newborn hearing screening fee as negotiated with the
46 provider and facility.

47 The benefits provided pursuant to this subsection shall be
48 provided to the same extent as for any other medical condition

1 under the health benefits plan, except that a deductible shall not be
2 applied for benefits provided pursuant to this subsection; however,
3 with respect to a small employer health benefits plan that qualifies
4 as a high deductible health plan for which qualified medical
5 expenses are paid using a health savings account established
6 pursuant to section 223 of the federal Internal Revenue Code of
7 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
8 benefits that represent preventive care as permitted by that federal
9 law, and shall not be applied as provided pursuant to section 16 of
10 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
11 all small employer health benefits plans in which the carrier has
12 reserved the right to change the premium.

13 l. The board shall consider including benefits for speech-
14 language pathology and audiology services, as rendered by speech-
15 language pathologists and audiologists within the scope of their
16 practices, in at least one of the standard policies and in at least one
17 of the five riders to be developed under this section.

18 m. Effective immediately for a health benefits plan issued on or
19 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
20 effective on the first 12-month anniversary date of a health benefits
21 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
22 et al.), the health benefits plans required pursuant to this section
23 that provide benefits for expenses incurred in the purchase of
24 prescription drugs shall provide benefits for expenses incurred in
25 the purchase of specialized non-standard infant formulas, when the
26 covered infant's physician has diagnosed the infant as having
27 multiple food protein intolerance and has determined such formula
28 to be medically necessary, and when the covered infant has not been
29 responsive to trials of standard non-cow milk-based formulas,
30 including soybean and goat milk. The coverage may be subject to
31 utilization review, including periodic review, of the continued
32 medical necessity of the specialized infant formula.

33 The benefits shall be provided to the same extent as for any other
34 prescribed items under the health benefits plan.

35 This subsection shall apply to all small employer health benefits
36 plans in which the carrier has reserved the right to change the
37 premium.

38 n. Effective immediately for a health benefits plan issued on or
39 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
40 and effective on the first 12-month anniversary date of a small
41 employer health benefits plan in effect on the effective date of
42 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
43 required pursuant to this section that qualify as high deductible
44 health plans for which qualified medical expenses are paid using a
45 health savings account established pursuant to section 223 of the
46 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
47 any plans offered by a State approved or federally qualified health
48 maintenance organization, shall contain benefits for expenses

1 incurred in connection with any medically necessary benefits
2 provided in-network that represent preventive care as permitted by
3 that federal law.

4 The benefits provided pursuant to this subsection shall be
5 provided to the same extent as for any other medical condition
6 under the health benefits plan, except that no deductible shall be
7 applied for benefits provided pursuant to this subsection. This
8 subsection shall apply to all small employer health benefits plans in
9 which the carrier has reserved the right to change the premium.

10 (cf: P.L.2023, c.194, s.3)

11
12 12. Section 7 of P.L.2019, c.360 (C.17B:27A-19.31) is amended
13 to read as follows:

14 7. a. An small employer health benefits plan that provides
15 hospital or medical expense benefits and is delivered, issued,
16 executed or renewed in this State, or approved for issuance or
17 renewal in this State by the Commissioner of Banking and
18 Insurance, on or after the effective date of this act, shall provide
19 coverage, without requiring any cost sharing, for the following
20 preventive services:

21 (1) evidence-based items or services that have in effect a rating
22 of "A" or "B" in the current recommendations of the United States
23 Preventive Services Task Force;

24 (2) immunizations that have in effect a recommendation from
25 the [Advisory Committee on Immunization Practices of the Centers
26 for Disease Control and Prevention] Department of Health, which
27 shall in making its recommendations consider the recommendations
28 of the Advisory Committee on Immunization Practices of the
29 Centers for Disease Control and Prevention in the federal
30 Department of Health and Human Services and, as appropriate, the
31 recommendations of the American Academy of Pediatrics, the
32 American Academy of Family Physicians, the American College of
33 Obstetricians and Gynecologists, and the American College of
34 Physicians;

35 (3) with respect to infants, children, and adolescents, evidence-
36 informed preventive care and screenings provided for in the
37 comprehensive guidelines supported by the Health Resources and
38 Services Administration; and

39 (4) with respect to women, any additional preventive care and
40 screenings not described in paragraph (1) as provided for in the
41 comprehensive guidelines supported by the Health Resources and
42 Services Administration.

43 b. (1) Except as provided in paragraph (2) of this subsection,
44 nothing in this section shall:

45 (a) require a plan which has a network of providers to provide
46 benefits for items or services described in subsection a. of this
47 section that are delivered by an out-of-network provider; or

1 (b) preclude a plan which has a network of providers from
2 imposing cost-sharing requirements for items or services described
3 in subsection a. of this section that are delivered by an out-of-
4 network provider.

5 (2) If a plan does not have in its network a provider who can
6 provide an item or service described in subsection a. of this section,
7 the plan shall cover the item or service when performed by an out-
8 of-network provider, and shall not impose cost sharing with respect
9 to that item or service.

10 c. (1) A plan shall provide coverage for an item or service
11 described in subsection a. of this section for plan years that begin
12 on or after the date that is one year after the date the
13 recommendation or guideline is issued.

14 (2) (a) Except as provided in subparagraph (b) of this paragraph,
15 a plan that is required to provide coverage for an item or service
16 described in subsection a. of this section on the first day of a plan
17 year shall provide coverage for that item or service through the last
18 day of the plan year.

19 (b) The commissioner may remove a coverage requirement for
20 an item or service during a plan year if the recommendation or
21 guideline changes or is no longer described in subsection a. of this
22 section.

23 d. This section shall apply to all small employer health benefits
24 plans in which the carrier has reserved the right to change the
25 premium.

26 (cf: P.L.2019, c.360, s.7)

27

28 13. Section 2 of P.L.2003, c.284 (C.18A:62-15.1) is amended to
29 read as follows:

30 2. a. Beginning in September 2004, a new student enrolling in a
31 public or private institution of higher education in this State shall
32 have received immunization for meningococcal disease as
33 recommended by the **Advisory Committee on Immunization**
34 **Practices of the Centers for Disease Control and Prevention]**
35 Department of Health, which shall consider the recommendations of
36 the Advisory Committee on Immunization Practices of the Centers
37 for Disease Control and Prevention in the federal Department of
38 Health and Human Services and, as appropriate, the
39 recommendations of the American Academy of Pediatrics, the
40 American Academy of Family Physicians, the American College of
41 Obstetricians and Gynecologists, and the American College of
42 Physicians, as a condition of attendance at that institution, except as
43 provided in section 3 of P.L.2003, c.284 (C.18A:62-15.2).

44 b. A student shall present evidence of the vaccination required
45 pursuant to subsection a. of this section to the institution in a
46 manner prescribed by the institution.

47 c. The Department of Health shall require each public or
48 private institution of higher education in this State to offer the

1 immunization required pursuant to subsection a. of this section to
2 its students through the institution's student health services program
3 or through a contractual agreement with a community health care
4 provider.

5 d. The Commissioner of Health shall adopt rules and
6 regulations pursuant to the "Administrative Procedure Act,"
7 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of
8 subsections a., b. and c. of this section and section 3 of P.L.2003,
9 c.284 (C.18A:62-15.2).

10 (cf: P.L.2019, c.332, s.1)

11
12 14. Section 7 of P.L.1995, c.316 (C.26:2-137.1) is amended to
13 read as follows:

14 7. The Department of Health shall specify by regulation,
15 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
16 (C.52:14B-1 et seq.):

17 a. The lead screening requirements provided for under
18 P.L.1995, c.316 (C.17:48E-35.10 et al.), including the age of the
19 child when initial screening should be conducted, the time intervals
20 between screening, when follow-up testing is required, the methods
21 that shall be used to conduct the lead screening, and, in accordance
22 with the latest recommendations of the federal Centers for Disease
23 Control and Prevention and the provisions of P.L.1995, c.328
24 (C.26:2-137.2 et seq.), the level of lead in the bloodstream that shall
25 necessitate the undertaking of responsive action; and

26 b. The childhood immunizations recommended by the
27 **【Advisory Committee on Immunization Practices of the United**
28 **States Public Health Service and the】** Department of Health, which
29 shall consider the recommendations of the Advisory Committee on
30 Immunization Practices of the Centers for Disease Control and
31 Prevention in the federal Department of Health and Human Services
32 and, as appropriate, the recommendations of the American
33 Academy of Pediatrics, the American Academy of Family
34 Physicians, the American College of Obstetricians and
35 Gynecologists, and the American College of Physicians.

36 (cf: P.L.2017, c.7, s.2)

37
38 15. Section 1 of P.L.2019, c.330 (C.26:2H-18.79) is amended to
39 read as follows:

40 1. a. As used in this act:

41 "Commissioner" means the Commissioner of Health.

42 "Health care facility" means a general or special hospital,
43 nursing home, or home health care agency licensed pursuant to
44 P.L.1971, c.136 (C.26:2H-1 et seq.).

45 b. Commencing with the onset of the first influenza season
46 next following the effective date of this act, each health care facility
47 shall establish and implement an annual influenza vaccination
48 program in accordance with the current recommendations of the

1 **【Advisory Committee on Immunization Practices of the federal**
2 **Centers for Disease Control and Prevention】** Department of Health,
3 which shall in making its recommendations consider the
4 recommendations of the Advisory Committee on Immunization
5 Practices of the Centers for Disease Control and Prevention in the
6 federal Department of Health and Human Services and, as
7 appropriate, the recommendations of the American Academy of
8 Pediatrics, the American Academy of Family Physicians, the
9 American College of Obstetricians and Gynecologists, and the
10 American College of Physicians, and any rules and regulations
11 adopted by the commissioner pursuant to this act.

12 c. For the purposes of its annual influenza vaccination
13 program, each health care facility shall:

14 (1) annually provide an on-site or off-site influenza vaccination
15 to each of its employees;

16 (2) require that each employee at the facility receive an
17 influenza vaccination annually, no later than December 31 of the
18 current influenza season as determined by the federal Centers for
19 Disease Control and Prevention, which vaccination shall be
20 provided by the health care facility, except that an employee may,
21 in lieu of receiving the influenza vaccination at the facility, present
22 acceptable proof, comprising:

23 (a) an attestation from the employee, which shall be submitted
24 in a form and manner designated by the facility, of a current
25 influenza vaccination if the employee receives the vaccination from
26 another vaccination source, which attestation shall include the lot
27 number of the vaccination the employee received or;

28 (b) a medical exemption, which shall be submitted using a form
29 designated by the Department of Health, stating that the influenza
30 vaccination for that employee is medically contraindicated, as
31 enumerated by the **【Advisory Committee on Immunization**
32 **Practices of the federal Centers for Disease Control and Prevention】**
33 Department of Health. An attestation of a medical exemption shall
34 be subject to approval by the facility following a review by the
35 facility to confirm the medical exemption is consistent with
36 standards enumerated by the **【Advisory Committee on**
37 **Immunization Practices】** Department of Health;

38 (3) maintain a record or attestation, as applicable, of influenza
39 vaccinations and medical exemptions for each employee and report
40 to the Department of Health, in a manner and according to a
41 schedule prescribed by the commissioner, the vaccination
42 percentage rate of its workforce in receiving influenza vaccinations
43 as part of the facility's annual vaccination program or by other
44 means as attested to by the workforce, as applicable. The report
45 may also include other information that the facility deems relevant
46 to its vaccination percentage rate, including, but not limited to, the
47 number of employees who received medical exemptions;

1 (4) provide an educational component to its program that is
2 designed to inform employees about: influenza vaccination; non-
3 vaccine influenza control measures; and the symptoms,
4 transmission, and potential impact of influenza;

5 (5) annually conduct an evaluation of the program with the goal
6 of improving the rate of vaccination among its employees; and

7 (6) require any employee who does not receive an influenza
8 vaccination to wear a surgical or procedural mask when in direct
9 contact with patients and in common areas, as specified in facility
10 policy, or to be removed from direct patient care responsibilities
11 during influenza season.

12 d. A health care facility may suspend its annual influenza
13 vaccination program pursuant to this act in the event of a shortage
14 of influenza vaccine as determined by the commissioner.

15 e. (1) The commissioner may assess such penalties and take
16 other actions against a health care facility, as provided in P.L.1971,
17 c.136 (C.26:2H-1 et seq.), or any rules and regulations adopted
18 pursuant thereto, for any determination by the commissioner of
19 noncompliance by a health care facility or any of its employees with
20 the provisions of this act.

21 (2) The commissioner shall seek to minimize any record-
22 keeping burden imposed on a health care facility pursuant to this act
23 and shall take such actions as are necessary to ensure the
24 confidentiality of any data furnished to the department pursuant to
25 this act that may contain information identifying an individual
26 employee.

27 (3) The commissioner shall make available to the public
28 aggregate data reported by a facility pursuant to paragraph (3) of
29 subsection c. of this section.

30 f. A health care facility shall not discharge or reduce the pay of
31 an employee who receives a medical exemption from the annual
32 influenza vaccination requirement.

33 g. Nothing in this section shall be construed to prohibit a health
34 care facility from adopting additional policies and procedures with
35 regard to the annual influenza vaccine that are not inconsistent with
36 the requirements of this section.

37 (cf: P.L.2019, c.330, s.1)

38
39 16. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to
40 read as follows:

41 4. A certificate of authority to establish and operate a health
42 maintenance organization in this State shall not be issued or
43 continued by the Commissioner of Banking and Insurance on or
44 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
45 unless the health maintenance organization offers health care
46 services to any enrollee which include:

47 a. Screening by blood lead measurement for lead poisoning for
48 children, including confirmatory blood lead testing as specified by

1 the Department of Health pursuant to section 7 of P.L.1995, c.316
2 (C.26:2-137.1); and medical evaluation and any necessary medical
3 follow-up and treatment for lead poisoned children.

4 b. All childhood immunizations as recommended by the
5 **【Advisory Committee on Immunization Practices of the United**
6 **States Public Health Service and the】** Department of Health
7 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】**, which
8 shall consider the recommendations of the Advisory Committee on
9 Immunization Practices of the Centers for Disease Control and
10 Prevention in the federal Department of Health and Human Services
11 and, as appropriate, the recommendations of the American
12 Academy of Pediatrics, the American Academy of Family
13 Physicians, the American College of Obstetricians and
14 Gynecologists, and the American College of Physicians. A health
15 maintenance organization shall notify its enrollees, in writing, of
16 any change in the health care services provided with respect to
17 childhood immunizations and any related changes in premium. The
18 notification shall be in a form and manner to be determined by the
19 Commissioner of Banking and Insurance.

20 c. Screening for newborn hearing loss by appropriate
21 electrophysiologic screening measures and periodic monitoring of
22 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
23 (C.26:2-103.1 et al.). Payment for this screening service shall be
24 separate and distinct from payment for routine new baby care in the
25 form of a newborn hearing screening fee as negotiated with the
26 provider and facility.

27 The health care services provided pursuant to this section shall
28 be provided to the same extent as for any other medical condition
29 under the contract, except that a deductible shall not be applied for
30 services provided pursuant to this section; however, with respect to
31 a contract that qualifies as a high deductible health plan for which
32 qualified medical expenses are paid using a health savings account
33 established pursuant to section 223 of the federal Internal Revenue
34 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied
35 for any services provided pursuant to this section that represent
36 preventive care as permitted by that federal law, and shall not be
37 applied as provided pursuant to section 12 of P.L.2005, c.248
38 (C.26:2J-4.29). This section shall apply to all contracts under
39 which the health maintenance organization has reserved the right to
40 change the schedule of charges for enrollee coverage.
41 (cf: P.L.2012, c.17, s.265)

42
43 17. Section 8 of P.L.2019, c.360 (C.26:2J-4.45) is amended to
44 read as follows:

45 8. a. A health maintenance organization contract that provides
46 hospital or medical expense benefits and is delivered, issued,
47 executed or renewed in this State, or approved for issuance or
48 renewal in this State by the Commissioner of Banking and

1 Insurance, on or after the effective date of this act, shall provide
2 coverage, without requiring any cost sharing, for the following
3 preventive services:

4 (1) evidence-based items or services that have in effect a rating
5 of "A" or "B" in the current recommendations of the United States
6 Preventive Services Task Force;

7 (2) immunizations that have in effect a recommendation from
8 the [Advisory Committee on Immunization Practices of the Centers
9 for Disease Control and Prevention] Department of Health, which
10 shall in making its recommendations consider the recommendations
11 of the Advisory Committee on Immunization Practices of the
12 Centers for Disease Control and Prevention in the federal
13 Department of Health and Human Services and, as appropriate, the
14 recommendations of the American Academy of Pediatrics, the
15 American Academy of Family Physicians, the American College of
16 Obstetricians and Gynecologists, and the American College of
17 Physicians;

18 (3) with respect to infants, children, and adolescents, evidence-
19 informed preventive care and screenings provided for in the
20 comprehensive guidelines supported by the Health Resources and
21 Services Administration; and

22 (4) with respect to women, any additional preventive care and
23 screenings not described in paragraph (1) as provided for in the
24 comprehensive guidelines supported by the Health Resources and
25 Services Administration.

26 b. (1) Except as provided in paragraph (2) of this subsection,
27 nothing in this section shall:

28 (a) require a contract which has a network of providers to
29 provide benefits for items or services described in subsection a. of
30 this section that are delivered by an out-of-network provider; or

31 (b) preclude a contract which has a network of providers from
32 imposing cost-sharing requirements for items or services described
33 in subsection a. of this section that are delivered by an out-of-
34 network provider.

35 (2) If a contract does not have in its network a provider who can
36 provide an item or service described in subsection a. of this section,
37 the contract shall cover the item or service when performed by an
38 out-of-network provider, and shall not impose cost sharing with
39 respect to that item or service.

40 c. (1) A contract shall provide coverage for an item or service
41 described in subsection a. of this section for plan years that begin
42 on or after the date that is one year after the date the
43 recommendation or guideline is issued.

44 (2) (a) Except as provided in subparagraph (b) of this paragraph,
45 a contract that is required to provide coverage for an item or service
46 described in subsection a. of this section on the first day of a plan
47 year shall provide coverage for that item or service through the last
48 day of the plan year.

1 (b) The commissioner may remove a coverage requirement for
2 an item or service during a plan year if the recommendation or
3 guideline changes or is no longer described in subsection a. of this
4 section.

5 d. The provisions of this section shall apply to those contracts
6 in which the health maintenance organization has reserved the right
7 to change the premium.

8 (cf: P.L.2019, c.360, s.8)

9
10 18. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
11 as follows:

12 6. a. Subject to the requirements of Title XIX of the federal
13 Social Security Act, the limitations imposed by this act and by the
14 rules and regulations promulgated pursuant thereto, the department
15 shall provide medical assistance to qualified applicants, including
16 authorized services within each of the following classifications:

17 (1) Inpatient hospital services

18 (2) Outpatient hospital services;

19 (3) Other laboratory and X-ray services;

20 (4) (a) Skilled nursing or intermediate care facility services;

21 (b) Early and periodic screening and diagnosis of individuals
22 who are eligible under the program and are under age 21, to
23 ascertain their physical or mental health status and the health care,
24 treatment, and other measures to correct or ameliorate defects and
25 chronic conditions discovered thereby, as may be provided in
26 regulation of the Secretary of the federal Department of Health and
27 Human Services and approved by the commissioner;

28 (5) Physician's services furnished in the office, the patient's
29 home, a hospital, a skilled nursing, or intermediate care facility or
30 elsewhere.

31 As used in this subsection, "laboratory and X-ray services"
32 includes HIV drug resistance testing, including, but not limited to,
33 genotype assays that have been cleared or approved by the federal
34 Food and Drug Administration, laboratory developed genotype
35 assays, phenotype assays, and other assays using phenotype
36 prediction with genotype comparison, for persons diagnosed with
37 HIV infection or AIDS.

38 b. Subject to the limitations imposed by federal law, by this
39 act, and by the rules and regulations promulgated pursuant thereto,
40 the medical assistance program may be expanded to include
41 authorized services within each of the following classifications:

42 (1) Medical care not included in subsection a.(5) above, or any
43 other type of remedial care recognized under State law, furnished
44 by licensed practitioners within the scope of their practice, as
45 defined by State law;

46 (2) Home health care services;

47 (3) Clinic services;

48 (4) Dental services;

- 1 (5) Physical therapy and related services;
- 2 (6) Prescribed drugs, dentures, and prosthetic devices; and
- 3 eyeglasses prescribed by a physician skilled in diseases of the eye
- 4 or by an optometrist, whichever the individual may select;
- 5 (7) Optometric services;
- 6 (8) Podiatric services;
- 7 (9) Chiropractic services;
- 8 (10) Psychological services;
- 9 (11) Inpatient psychiatric hospital services for individuals under
- 10 21 years of age, or under age 22 if they are receiving such services
- 11 immediately before attaining age 21;
- 12 (12) Other diagnostic, screening, preventative, and rehabilitative
- 13 services, and other remedial care;
- 14 (13) Inpatient hospital services, nursing facility services, and
- 15 immediate care facility services for individuals 65 years of age or
- 16 over in an institution for mental diseases;
- 17 (14) Intermediate care facility services;
- 18 (15) Transportation services;
- 19 (16) Services in connection with the inpatient or outpatient
- 20 treatment or care of substance use disorder, when the treatment is
- 21 prescribed by a physician and provided in a licensed hospital or in a
- 22 narcotic and substance use disorder treatment center approved by
- 23 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
- 24 et. seq.) and whose staff includes a medical director, and limited
- 25 those services eligible for federal financial participation under Title
- 26 XIX of the federal Social Security Act;
- 27 (17) Any other medical care and any other type of remedial care
- 28 recognized under State law, specified by the Secretary of the federal
- 29 Department of Health and Human Services, and approved by the
- 30 commissioner;
- 31 (18) Comprehensive maternity care, which may include: the
- 32 basic number of prenatal and postpartum visits recommended by the
- 33 American College of Obstetrics and Gynecology; additional
- 34 prenatal and postpartum visits that are medically necessary;
- 35 necessary laboratory, nutritional assessment and counseling, health
- 36 education, personal counseling, managed care, outreach, and
- 37 follow-up services; treatment of conditions which may complicate
- 38 pregnancy doula care; and physician or certified nurse midwife
- 39 delivery services. For the purposes of this paragraph, "doula"
- 40 means a trained professional who provides continuous physical,
- 41 emotional, and informational support to a mother before, during,
- 42 and shortly after childbirth, to help her to achieve the healthiest,
- 43 most satisfying experience possible;
- 44 (19) Comprehensive pediatric care, which may include:
- 45 ambulatory, preventive, and primary care health services. The
- 46 preventive services shall include, at a minimum, the basic number
- 47 of preventive visits recommended by the American Academy of
- 48 Pediatrics;

1 (20) Services provided by a hospice which is participating in the
2 Medicare program established pursuant to Title XVIII of the Social
3 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
4 services shall be provided subject to approval of the Secretary of
5 the federal Department of Health and Human Services for federal
6 reimbursement;

7 (21) Mammograms, subject to approval of the Secretary of the
8 federal Department of Health and Human Services for federal
9 reimbursement, including one baseline mammogram for women
10 who are at least 35 but less than 40 years of age; one mammogram
11 examination every two years or more frequently, if recommended
12 by a physician, for women who are at least 40 but less than 50 years
13 of age; and one mammogram examination every year for women
14 age 50 and over;

15 (22) Upon referral by a physician, advanced practice nurse, or
16 physician assistant of a person who has been diagnosed with
17 diabetes, gestational diabetes, or pre-diabetes, in accordance with
18 standards adopted by the American Diabetes Association:

19 (a) Expenses for diabetes self-management education or training
20 to ensure that a person with diabetes, gestational diabetes, or pre-
21 diabetes can optimize metabolic control, prevent and manage
22 complications, and maximize quality of life. Diabetes self-
23 management education shall be provided by an in-State provider
24 who is:

25 (i) a licensed, registered, or certified health care professional
26 who is certified by the National Certification Board of Diabetes
27 Educators as a Certified Diabetes Educator, or certified by the
28 American Association of Diabetes Educators with a Board
29 Certified-Advanced Diabetes Management credential, including, but
30 not limited to: a physician, an advanced practice or registered nurse,
31 a physician assistant, a pharmacist, a chiropractor, a dietitian
32 registered by a nationally recognized professional association of
33 dietitians, or a nutritionist holding a certified nutritionist specialist
34 (CNS) credential from the Board for Certification of Nutrition
35 Specialists; or

36 (ii) an entity meeting the National Standards for Diabetes Self-
37 Management Education and Support, as evidenced by a recognition
38 by the American Diabetes Association or accreditation by the
39 American Association of Diabetes Educators;

40 (b) Expenses for medical nutrition therapy as an effective
41 component of the person's overall treatment plan upon a: diagnosis
42 of diabetes, gestational diabetes, or pre-diabetes; change in the
43 beneficiary's medical condition, treatment, or diagnosis; or
44 determination of a physician, advanced practice nurse, or physician
45 assistant that reeducation or refresher education is necessary.
46 Medical nutrition therapy shall be provided by an in-State provider
47 who is a dietitian registered by a nationally-recognized professional
48 association of dietitians, or a nutritionist holding a certified

- 1 nutritionist specialist (CNS) credential from the Board for
2 Certification of Nutrition Specialists, who is familiar with the
3 components of diabetes medical nutrition therapy;
- 4 (c) For a person diagnosed with pre-diabetes, items and services
5 furnished under an in-State diabetes prevention program that meets
6 the standards of the National Diabetes Prevention Program, as
7 established by the federal Centers for Disease Control and
8 Prevention; and
- 9 (d) Expenses for any medically appropriate and necessary
10 supplies and equipment recommended or prescribed by a physician,
11 advanced practice nurse, or physician assistant for the management
12 and treatment of diabetes, gestational diabetes, or pre-diabetes,
13 including, but not limited to: equipment and supplies for self-
14 management of blood glucose; insulin pens; insulin pumps and
15 related supplies; and other insulin delivery devices;
- 16 (23) Expenses incurred for the provision of group prenatal
17 services to a pregnant woman, provided that:
- 18 (a) the provider of such services, which shall include, but not be
19 limited to, a federally qualified health center or a community health
20 center operating in the State:
- 21 (i) is a site accredited by the Centering Healthcare Institute, or is
22 a site engaged in an active implementation contract with the
23 Centering Healthcare institute, that utilizes the Centering Pregnancy
24 model; and
- 25 (ii) incorporates the applicable information outlined in any best
26 practices manual for prenatal and postpartum maternal care
27 developed by the Department of Health into the curriculum for each
28 group prenatal visit;
- 29 (b) each group prenatal care visit is at least 1.5 hours in duration,
30 with a. minimum of two women and a maximum of 20 women in
31 participation; and
- 32 (c) no more than 10 group prenatal care visits occur per
33 pregnancy. As used in this paragraph, "group prenatal care
34 services" means a series of prenatal care visits provided in a group
35 setting which are based upon the Centering Pregnancy model
36 developed by the Centering Healthcare Institute and which include
37 health assessments, social and clinical support, and educational
38 activities;
- 39 (24) Expenses incurred for the provision of pasteurized donated
40 human breast milk, which shall include human milk fortifiers if
41 indicated in a medical order provided by a licensed medical
42 practitioner, to an infant under the age of six months; provided that
43 the milk is obtained from a human milk bank that meets quality
44 guidelines established by the Department of Health and a licensed
45 medical practitioner has issued a medical order for the infant under
46 at least one of the following circumstances:
- 47 (a) the infant is medically or physically unable to receive
48 maternal breast milk or participate in breast feeding, or the infant's

1 mother is medically or physically unable to produce maternal breast
2 milk in sufficient quantities or participate in breast feeding despite
3 optimal lactation support; or

4 (b) the infant meets any of the following conditions:

5 (i) a body weight below healthy levels, as determined by the
6 licensed medical practitioner issuing the medical order for the
7 infant;

8 (ii) the infant has a congenital or acquired condition that places
9 the infant at a high risk for development of necrotizing
10 enterocolitis; or

11 (iii) the infant has a congenital or acquired condition that may
12 benefit from the use of donor breast milk and human milk fortifiers,
13 as determined by the Department of Health;

14 (25) Comprehensive tobacco cessation benefits to an individual
15 who is 18 years of age or older, or who is pregnant. Coverage shall
16 include: brief and high intensity individual counseling, brief and
17 high intensity group counseling, and telemedicine as defined by
18 section 1 of P.L.2017, c.117 (C.45:1-61); all medications approved
19 for tobacco cessation by the U.S. Food and Drug Administration;
20 and other tobacco cessation counseling recommended by the
21 Treating Tobacco Use and Dependence Clinical Practice Guideline
22 issued by the U.S. Public Health Service. Notwithstanding the
23 provisions of any other law, rule, or regulation to the contrary, and
24 except as otherwise provided in this section:

25 (a) Information regarding the availability of the tobacco
26 cessation services described in this paragraph shall be provided to
27 all individuals authorized to receive the tobacco cessation services
28 pursuant to this paragraph at the following times: no later than 90
29 days after the effective date of P.L.2019, c.473: upon the
30 establishment of an individual's eligibility for medical assistance;
31 and upon the redetermination of an individual's eligibility for
32 medical assistance;

33 (b) The following conditions shall not be imposed on any
34 tobacco cessation services provided pursuant to this paragraph:
35 copayments or any other forms of cost-sharing, including
36 deductibles; counseling requirements for medication; stepped care
37 therapy or similar restrictions requiring the use of one service prior
38 to another; limits on the duration of services; or annual or lifetime
39 limits on the amount, frequency, or cost of services, including, but
40 not limited to, annual or lifetime limits on the number of covered
41 attempts to quit; and

42 (c) Prior authorization requirements shall not be imposed on any
43 tobacco cessation services provided pursuant to this paragraph
44 except in the following circumstances where prior authorization
45 may be required: for a treatment that exceeds the duration
46 recommended by the most recently published United States Public
47 Health Service clinical practice guidelines on treating tobacco use

1 and dependence; or for services associated with more than two
2 attempts to quit within a 12-month period;

3 (26) Provided that there is federal financial participation
4 available, benefits for expenses incurred in conducting a colorectal
5 cancer screening in accordance with United States Preventive
6 Services Task Force recommendations. The method and frequency
7 of screening to be utilized shall be in accordance with the most
8 recent published recommendations of the United States Preventive
9 Services Task Force and as determined medically necessary by the
10 covered person's physician, in consultation with the covered person.

11 No deductible, coinsurance, copayment, or any other cost-
12 sharing requirement shall be imposed for a colonoscopy performed
13 following a positive result on a non-colonoscopy, colorectal cancer
14 screening test recommended by the United States Preventive
15 Services Task Force; and

16 (27) (a) Within 24 months of the effective date of P.L.2023,
17 c.187 (C.30:4D-6u et al.), and conditional on the receipt of all
18 necessary federal approvals and the securing of federal financial
19 participation pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u),
20 community-based palliative care benefits which shall include, but
21 not be limited to, all of the following:

22 (i) specialized medical care and emotional and spiritual support
23 for beneficiaries with serious advanced illnesses;

24 (ii) relief of symptoms, pain, and stress of serious illness;

25 (iii) improvement of quality of life for both the beneficiary and
26 the beneficiary's family; and

27 (iv) appropriate care for any age and for any stage of serious
28 illness, along with curative treatment.

29 (b) Benefits provided under this paragraph shall include, but
30 shall not be limited to, services provided by a hospice pursuant to
31 paragraph (20) of subsection b. of this section, provided that:

32 (i) hospice services may be provided at the same time that
33 curative treatment is available, to the extent that services are not
34 duplicative;

35 (ii) hospice services may be provided to beneficiaries whose
36 conditions may result in death, regardless of the estimated length of
37 the beneficiary's remaining period of life; and

38 (iii) the Division of Medical Assistance and Health Services in
39 the Department of Human Services may include any other service
40 deemed appropriate under the benefits provided under this
41 paragraph.

42 (c) Providers authorized to deliver benefits provided under this
43 paragraph shall include Medicaid-approved licensed hospice
44 agencies, Medicaid-approved home health agencies licensed to
45 provide hospice care, and other Medicaid-approved licensed health
46 care providers.

1 (d) Nothing in this paragraph shall be construed to result in the
2 elimination or reduction of covered benefits or services under the
3 Medicaid program.

4 (e) This paragraph shall not affect a beneficiary's eligibility to
5 receive, concurrently with services provided for in this paragraph,
6 any services, including home health services, for which the
7 beneficiary would have been eligible in the absence of this
8 paragraph, to the extent that services are not duplicative.

9 c. Payments for the foregoing services, goods and supplies
10 furnished pursuant to this act shall be made to the extent authorized
11 by this act, the rules and regulations promulgated pursuant thereto
12 and, where applicable, subject to the agreement of insurance
13 provided for under this act. The payments shall constitute payment
14 in full to the provider on behalf of the recipient. Every provider
15 making a claim for payment pursuant to this act shall certify in
16 writing on the claim submitted that no additional amount will be
17 charged to the recipient, the recipient's family, the recipient's
18 representative or others on the recipient's behalf for the services,
19 goods, and supplies furnished pursuant to this act.

20 No provider whose claim for payment pursuant to this act has
21 been denied because the services, goods, or supplies were
22 determined to be medically unnecessary shall seek reimbursement
23 from the recipient, his family, his representative or others on his
24 behalf for such services, goods, and supplies provided pursuant to
25 this act; provided, however, a provider may seek reimbursement
26 from a recipient for services, goods, or supplies not authorized by
27 this act, if the recipient elected to receive the services, goods or
28 supplies with the knowledge that they were not authorized.

29 d. Any individual eligible for medical assistance (including
30 drugs) may obtain such assistance from any person qualified to
31 perform the service or services required (including an organization
32 which provides such services, or arranges for their availability on a
33 prepayment basis), who undertakes to provide the individual such
34 services.

35 No copayment or other form of cost-sharing shall be imposed on
36 any individual eligible for medical assistance, except as mandated
37 by federal law as a condition of federal financial participation.

38 e. Anything in this act to the contrary notwithstanding, no
39 payments for medical assistance shall be made under this act with
40 respect to care or services for any individual who:

41 (1) Is an inmate of a public institution (except as a patient in a
42 medical institution); provided, however, that an individual who is
43 otherwise eligible may continue to receive services for the month in
44 which he becomes an inmate, should the commissioner determine to
45 expand the scope of Medicaid eligibility to include such an
46 individual, subject to the limitations imposed by federal law and
47 regulations, or

- 1 (2) Has not attained 65 years of age and who is a patient in an
2 institution for mental diseases, or
- 3 (3) Is over 21 years of age and who is receiving inpatient
4 psychiatric hospital services in a psychiatric facility; provided,
5 however, that an individual who was receiving such services
6 immediately prior to attaining age 21 may continue to receive such
7 services until the individual reaches age 22. Nothing in this
8 subsection shall prohibit the commissioner from extending medical
9 assistance to all eligible persons receiving inpatient psychiatric
10 services; provided that there is federal financial participation
11 available.
- 12 f. (1) A third party as defined in section 3 of P.L.1968, c.413
13 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
14 this or another state when determining the person's eligibility for
15 enrollment or the provision of benefits by that third party.
- 16 (2) In addition, any provision in a contract of insurance, health
17 benefits plan, or other health care coverage document, will, trust,
18 agreement, court order, or other instrument which reduces or
19 excludes coverage or payment for health care-related goods and
20 services to or for an individual because of that individual's actual or
21 potential eligibility for or receipt of Medicaid benefits shall be null
22 and void, and no payments shall be made under this act as a result
23 of any such provision.
- 24 (3) Notwithstanding any provision of law to the contrary, the
25 provisions of paragraph (2) of this subsection shall not apply to a
26 trust agreement that is established pursuant to 42 U.S.C.
27 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
28 provided by government entities to a person who is disabled as
29 defined in section 1614(a)(3) of the federal Social Security Act (42
30 U.S.C. s.1382c (a)(3)).
- 31 g. The following services shall be provided to eligible
32 medically needy individuals as follows:
- 33 (1) Pregnant women shall be provided prenatal care and delivery
34 services and postpartum care, including the services cited in
35 subsections a.(1), (3), and (5) of this section and subsections b.(1)-
36 (10), (12), (15), and (17) of this section, and nursing facility
37 services cited in subsection b.(13) of this section.
- 38 (2) Dependent children shall be provided with services cited in
39 subsections a.(3) and (5) of this section and subsections b.(1), (2),
40 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
41 nursing facility services cited in subsection b.(13) of this section.
- 42 (3) Individuals who are 65 years of age or older shall be
43 provided with services cited in subsections a.(3) and (5) of this
44 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
45 (7), (8), (10), (12), (15), and (17) of this section, and nursing
46 facility services cited in subsection b.(13) of this section.
- 47 (4) Individuals who are blind or disabled shall be provided with
48 services cited in subsections a.(3) and (5) of this section and

1 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
2 3 (12), (15), and (17) of this section, and nursing facility services
3 cited in subsection b.(13) of this section.

4 (5) (a) Inpatient hospital services, subsection a.(1) of this
5 section, shall only be provided to eligible medically needy
6 individuals, other than pregnant women, if the federal Department
7 of Health and Human Services discontinues the State's waiver to
8 establish inpatient hospital reimbursement rates for the Medicare
9 and Medicaid programs under the authority of section 601(c)(3) of
10 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
11 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
12 extended to other eligible medically needy individuals if the federal
13 Department of Health and Human Services directs that these
14 services be included.

15 (b) Outpatient hospital services, subsection a.(2) of this section,
16 shall only be provided to eligible medically needy individuals if the
17 federal Department of Health and Human Services discontinues the
18 State's waiver to establish outpatient hospital reimbursement rates
19 for the Medicare and Medicaid programs under the authority of
20 section 601(c)(3) of the Social Security Amendments of 1983,
21 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
22 services may be extended to all or to certain medically needy
23 individuals if the federal Department of Health and Human Services
24 directs that these services be included. However, the use of
25 outpatient hospital services shall be limited to clinic services and to
26 emergency room services for injuries and significant acute medical
27 conditions.

28 (c) The division shall monitor the use of inpatient and outpatient
29 hospital services by medically needy persons.

30 h. In the case of a qualified disabled and working individual
31 pursuant to section h6408 of Pub.L.101-239 (42 U.S.C. s.1396d),
32 the only medical assistance provided under this act shall be the
33 payment of premiums for Medicare part A under 42 U.S.C.
34 ss.1395i-2 and 1395r.

35 i. In the case of a specified low-income Medicare beneficiary
36 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
37 assistance provided under this act shall be the payment of premiums
38 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
39 U.S.C. s.1396d(p)(3)(A)(ii).

40 j. In the case of a qualified individual pursuant to 42 U.S.C.
41 s.1396a(aa), the only medical assistance provided under this act
42 shall be payment for authorized services provided during the period
43 in which the individual requires treatment for breast or cervical
44 cancer, in accordance with criteria established by the commissioner.

45 k. In the case of a qualified individual pursuant to 42 U.S.C.
46 s.1396a(ii), the only medical assistance provided under this act shall
47 be payment for family planning services and supplies as described
48 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and

1 treatment services that are provided pursuant to a family planning
2 service in a family planning setting.

3 1. As used in paragraph (12) of subsection b. of this section,
4 preventative care includes, but is not limited to, immunizations that
5 have in effect a recommendation from the Department of Health,
6 which shall in making its recommendations consider the
7 recommendations of the Advisory Committee on Immunization
8 Practices of the Centers for Disease Control and Prevention in the
9 federal Department of Health and Human Services and, as
10 appropriate, the recommendations of the American Academy of
11 Pediatrics, the American Academy of Family Physicians, the
12 American College of Obstetricians and Gynecologists, and the
13 American College of Physicians.

14 (cf: P.L.2023, c.187, s.1)

15
16 19. Section 9 of P.L.2019, c.360 (C.52:14-17.29dd) is amended
17 to read as follows:

18 9. a. The State Health Benefits Commission shall ensure that
19 every contract purchased by the commission on or after the
20 effective date of this act that provides hospital or medical expense
21 benefits shall provide coverage, without requiring any cost sharing,
22 for the following preventive services:

23 (1) evidence-based items or services that have in effect a rating
24 of "A" or "B" in the current recommendations of the United States
25 Preventive Services Task Force;

26 (2) immunizations that have in effect a recommendation from
27 the **【Advisory Committee on Immunization Practices of the Centers**
28 **for Disease Control and Prevention】** Department of Health, which
29 shall in making its recommendations consider the recommendations
30 of the Advisory Committee on Immunization Practices of the
31 Centers for Disease Control and Prevention in the federal
32 Department of Health and Human Services and, as appropriate, the
33 recommendations of the American Academy of Pediatrics, the
34 American Academy of Family Physicians, the American College of
35 Obstetricians and Gynecologists, and the American College of
36 Physicians;

37 (3) with respect to infants, children, and adolescents, evidence-
38 informed preventive care and screenings provided for in the
39 comprehensive guidelines supported by the Health Resources and
40 Services Administration; and

41 (4) with respect to women, any additional preventive care and
42 screenings not described in paragraph (1) as provided for in the
43 comprehensive guidelines supported by the Health Resources and
44 Services Administration.

45 b. (1) Except as provided in paragraph (2) of this subsection,
46 nothing in this section shall:

1 (a) require a contract which has a network of providers to
2 provide benefits for items or services described in subsection a. of
3 this section that are delivered by an out-of-network provider; or

4 (b) preclude a contract which has a network of providers from
5 imposing cost-sharing requirements for items or services described
6 in subsection a. of this section that are delivered by an out-of-
7 network provider.

8 (2) If a contract does not have in its network a provider who can
9 provide an item or service described in subsection a. of this section,
10 the contract shall cover the item or service when performed by an
11 out-of-network provider, and shall not impose cost sharing with
12 respect to that item or service.

13 c. (1) A contract shall provide coverage for an item or service
14 described in subsection a. of this section for plan years that begin
15 on or after the date that is one year after the date the
16 recommendation or guideline is issued.

17 (2) (a) Except as provided in subparagraph (b) of this paragraph,
18 a contract that is required to provide coverage for an item or service
19 described in subsection a. of this section on the first day of a plan
20 year shall provide coverage for that item or service through the last
21 day of the plan year.

22 (b) The commissioner may remove a coverage requirement for
23 an item or service during a plan year if the recommendation or
24 guideline changes or is no longer described in subsection a. of this
25 section.

26 (cf: P.L.2019, c.360, s.9)

27
28 20. Section 10 of P.L.2019, c.360 (C.52:14-17.46.6o) is amended
29 to read as follows:

30 10. a. The School Employees' Health Benefits Commission shall
31 ensure that every contract purchased by the commission on or after
32 the effective date of this act that provides hospital or medical
33 expense benefits shall provide coverage, without requiring any cost
34 sharing, for the following preventive services:

35 (1) evidence-based items or services that have in effect a rating
36 of "A" or "B" in the current recommendations of the United States
37 Preventive Services Task Force;

38 (2) immunizations that have in effect a recommendation from
39 the **【Advisory Committee on Immunization Practices of the Centers**
40 **for Disease Control and Prevention】** Department of Health, which
41 shall in making its recommendations consider the recommendations
42 of the Advisory Committee on Immunization Practices of the
43 Centers for Disease Control and Prevention in the federal
44 Department of Health and Human Services and, as appropriate, the
45 recommendations of the American Academy of Pediatrics, the
46 American Academy of Family Physicians, the American College of
47 Obstetricians and Gynecologists, and the American College of
48 Physicians;

1 (3) with respect to infants, children, and adolescents, evidence-
2 informed preventive care and screenings provided for in the
3 comprehensive guidelines supported by the Health Resources and
4 Services Administration; and

5 (4) with respect to women, any additional preventive care and
6 screenings not described in paragraph (1) as provided for in the
7 comprehensive guidelines supported by the Health Resources and
8 Services Administration.

9 b. (1) Except as provided in paragraph (2) of this subsection,
10 nothing in this section shall:

11 (a) require a contract which has a network of providers to
12 provide benefits for items or services described in subsection a. of
13 this section that are delivered by an out-of-network provider; or

14 (b) preclude a contract which has a network of providers from
15 imposing cost-sharing requirements for items or services described
16 in subsection a. of this section that are delivered by an out-of-
17 network provider.

18 (2) If a contract does not have in its network a provider who can
19 provide an item or service described in subsection a. of this section,
20 the contract shall cover the item or service when performed by an
21 out-of-network provider, and shall not impose cost sharing with
22 respect to that item or service.

23 c. (1) A contract shall provide coverage for an item or service
24 described in subsection a. of this section for plan years that begin
25 on or after the date that is one year after the date the
26 recommendation or guideline is issued.

27 (2) (a) Except as provided in subparagraph (b) of this paragraph,
28 a contract that is required to provide coverage for an item or service
29 described in subsection a. of this section on the first day of a plan
30 year shall provide coverage for that item or service through the last
31 day of the plan year.

32 (b) The commissioner may remove a coverage requirement for
33 an item or service during a plan year if the recommendation or
34 guideline changes or is no longer described in subsection a. of this
35 section.

36 (cf: P.L.2019, c.360, s.10)

37
38 21. The head of each State agency shall adopt such rules and
39 regulations, pursuant to the "Administrative Procedure Act,"
40 P.L.1968, c.410 (C.52:14B-1 et seq.), as the head of the State
41 agency may deem necessary, in order to replace any references to
42 the immunization or vaccination recommendations or guidance of
43 the Advisory Committee on Immunization Practices of the federal
44 Centers for Disease Control and Prevention in rule or regulation
45 with references to the recommendations of, and guidance issued by
46 the Department of Health, which shall in making its
47 recommendations consider the recommendations of the Advisory
48 Committee on Immunization Practices of the Centers for Disease

1 Control and Prevention in the federal Department of Health and
2 Human Services and, as appropriate, the recommendations of the
3 American Academy of Pediatrics, the American Academy of Family
4 Physicians, the American College of Obstetricians and
5 Gynecologists, and the American College of Physicians.
6

7 22. This act shall take effect immediately and shall apply to
8 policies or contracts issued or renewed on or after the effective
9 date.
10

11

12

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14 Revises certain references to Advisory Committee on
15 Immunization Practices in statutory and regulatory law; Requires
16 health benefits coverage for certain immunizations recommended
17 by DOH.