

P.L. 2025, CHAPTER 386, *approved January 20, 2026*
Assembly, No. 5785 (*Second Reprint*)

1 AN ACT concerning ²**[preventive services]** annual wellness visits²
2 and amending P.L.2019, c.360.
3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:
6
7 1. Section 1 of P.L.2019, c.360 (C.17:48-6tt) is amended to
8 read as follows:
9 1. a. A hospital service corporation contract that provides
10 hospital or medical expense benefits and is delivered, issued,
11 executed or renewed in this State, or approved for issuance or
12 renewal in this State by the Commissioner of Banking and
13 Insurance, on or after the effective date of this act, shall provide
14 coverage, without requiring any cost sharing, for the following
15 preventive services:
16 (1) evidence-based items or services that have in effect a rating
17 of "A" or "B" in the current recommendations of the United States
18 Preventive Services Task Force;
19 (2) immunizations that have in effect a recommendation from
20 the Advisory Committee on Immunization Practices of the Centers
21 for Disease Control and Prevention;
22 (3) with respect to infants, children, and adolescents, evidence-
23 informed preventive care and screenings provided for in the
24 comprehensive guidelines supported by the Health Resources and
25 Services Administration; and
26 (4) with respect to women, any additional preventive care and
27 screenings not described in paragraph (1) as provided for in the
28 comprehensive guidelines supported by the Health Resources and
29 Services Administration.
30 b. (1) Except as provided in paragraph (2) of this subsection,
31 nothing in this section shall:
32 (a) require a contract which has a network of providers to
33 provide benefits for items or services described in subsection a. of
34 this section that are delivered by an out-of-network provider; or
35 (b) preclude a contract which has a network of providers from
36 imposing cost-sharing requirements for items or services described
37 in subsection a. of this section that are delivered by an out-of-
38 network provider.

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.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AFI committee amendments adopted December 11, 2025.

²Senate SBA committee amendments adopted January 8, 2026.

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

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

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

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

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

e. ²[A contract shall provide coverage for preventive services that are recommended on an annual basis at least once per calendar year, without requiring any waiting period ¹, except the contract may require a waiting period that is medically necessary to ensure the safety of the services¹. ¹[This requirement shall not be construed to add any limitation to the frequency of coverage for preventive services]

Nothing in this subsection shall require coverage of duplicative preventive services unless a provider determines the duplicative services are clinically indicated¹. As used in this subsection, "calendar year" means the 12-month period beginning January 1 and ending December 31.] With respect to an annual wellness visit for a covered member who is over three years of age, a carrier is required to cover only one wellness visit per plan year or calendar year, as provided for under the health benefits plan contract, but may not impose a waiting period for the wellness visit².

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

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

2. a. A medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage, without 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;

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

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

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

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

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

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

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

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

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

42 d. The provisions of this section shall apply to those medical
43 service corporation contracts in which the medical service
44 corporation has reserved the right to change the premium.

45 e. ²A contract shall provide coverage for preventive services
46 that are recommended on an annual basis at least once per calendar
47 year, without requiring any waiting period ¹, except the contract
48 may require a waiting period that is medically necessary to ensure

1 the safety of the services¹. ¹["This requirement shall not be
2 construed to add any limitation to the frequency of coverage for
3 preventive services"]

4 Nothing in this subsection shall require coverage of duplicative
5 preventive services unless a provider determines the duplicative
6 services are clinically indicated¹. As used in this subsection,
7 "calendar year" means the 12-month period beginning January 1
8 and ending December 31.] With respect to an annual wellness visit
9 for a covered member who is over three years of age, a carrier is
10 required to cover only one wellness visit per plan year or calendar
11 year, as provided for under the health benefits plan contract, but
12 may not impose a waiting period for the wellness visit².

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

14
15 3. Section 3 of P.L.2019, c.360 (C.17:48E-35.44) is amended
16 to read as follows:

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

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

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

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

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

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

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

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

3 c. (1) A contract 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 contract 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. The provisions of this section shall apply to those health
17 service corporation contracts in which the health service
18 corporation has reserved the right to change the premium.

19 e. ²[A contract shall provide coverage for preventive services
20 that are recommended on an annual basis at least once per calendar
21 year, without requiring any waiting period ¹, except the contract
22 may require a waiting period that is medically necessary to ensure
23 the safety of the services¹. ¹[This requirement shall not be
24 construed to add any limitation to the frequency of coverage for
25 preventive services]

26 Nothing in this subsection shall require coverage of duplicative
27 preventive services unless a provider determines the duplicative
28 services are clinically indicated¹. As used in this subsection,
29 "calendar year" means the 12-month period beginning January 1
30 and ending December 31.] With respect to an annual wellness visit
31 for a covered member who is over three years of age, a carrier is
32 required to cover only one wellness visit per plan year or calendar
33 year, as provided for under the health benefits plan contract, but
34 may not impose a waiting period for the wellness visit².

35 (cf: P.L.2019, c.360, s.3)

36

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

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

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

1 (2) immunizations that have in effect a recommendation from
2 the Advisory Committee on Immunization Practices of the Centers
3 for Disease Control and Prevention;

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

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

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

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

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

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

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

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

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

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

41 e. ²A policy shall provide coverage for preventive services
42 that are recommended on an annual basis at least once per calendar
43 year, without requiring any waiting period ¹, except the policy may
44 require a waiting period that is medically necessary to ensure the
45 safety of the services ¹. ¹This requirement shall not be construed to
46 add any limitation to the frequency of coverage for preventive
47 services】

1 Nothing in this subsection shall require coverage of duplicative
2 preventive services unless a provider determines the duplicative
3 services are clinically indicated¹. As used in this subsection,
4 "calendar year" means the 12-month period beginning January 1
5 and ending December 31.】 With respect to an annual wellness visit
6 for a covered member who is over three years of age, a carrier is
7 required to cover only one wellness visit per plan year or calendar
8 year, as provided for under the policy, but may not impose a
9 waiting period for the wellness visit².

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

11
12 5. Section 5 of P.L.2019, c.360 (C.17B:27-46.1tt) is amended
13 to read as follows:

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

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

23 (2) immunizations that have in effect a recommendation from
24 the Advisory Committee on Immunization Practices of the Centers
25 for Disease Control and Prevention;

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

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

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

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

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

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

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

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

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

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

16 e. ²["A policy shall provide coverage for preventive services
17 that are recommended on an annual basis at least once per calendar
18 year, without requiring any waiting period ¹, except the policy may
19 require a waiting period that is medically necessary to ensure the
20 safety of the services¹. ¹["This requirement shall not be construed to
21 add any limitation to the frequency of coverage for preventive
22 services"]

23 Nothing in this subsection shall require coverage of duplicative
24 preventive services unless a provider determines the duplicative
25 services are clinically indicated¹. As used in this subsection,
26 "calendar year" means the 12-month period beginning January 1
27 and ending December 31"] With respect to an annual wellness visit
28 for a covered member who is over three years of age, a carrier is
29 required to cover only one wellness visit per plan year or calendar
30 year, as provided for under the policy, but may not impose a
31 waiting period for the wellness visit².

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

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

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

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

45 (2) immunizations that have in effect a recommendation from
46 the Advisory Committee on Immunization Practices of the Centers
47 for Disease Control and Prevention;

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

14 (b) preclude a plan 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 plan 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 plan shall cover the item or service when performed by an out-
21 of-network provider, and shall not impose cost sharing with respect
22 to that item or service.

23 c. (1) A plan 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 plan 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 d. This section shall apply to all individual health benefits
37 plans in which the carrier has reserved the right to change the
38 premium.

39 e. ²[A plan shall provide coverage for preventive services that
40 are recommended on an annual basis at least once per calendar year,
41 without requiring any waiting period ¹, except the plan may require
42 a waiting period that is medically necessary to ensure the safety of
43 the services ¹. ¹[This requirement shall not be construed to add any
44 limitation to the frequency of coverage for preventive services]

45 Nothing in this subsection shall require coverage of duplicative
46 preventive services unless a provider determines the duplicative
47 services are clinically indicated¹. As used in this subsection,
48 "calendar year" means the 12-month period beginning January 1

1 and ending December 31.] With respect to an annual wellness visit
2 for a covered member who is over three years of age, a carrier is
3 required to cover only one wellness visit per plan year or calendar
4 year, as provided for under the health benefits plan contract, but
5 may not impose a waiting period for the wellness visit².

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

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

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

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

20 (2) immunizations that have in effect a recommendation from
21 the Advisory Committee on Immunization Practices of the Centers
22 for Disease Control and Prevention;

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

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

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

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

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

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

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

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

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

10 d. This section shall apply to all small employer health benefits
11 plans in which the carrier has reserved the right to change the
12 premium.

13 e. ²[A plan shall provide coverage for preventive services that
14 are recommended on an annual basis at least once per calendar year,
15 without requiring any waiting period ¹, except the plan may require
16 a waiting period that is medically necessary to ensure the safety of
17 the services¹. ¹[This requirement shall not be construed to add any
18 limitation to the frequency of coverage for preventive services]

19 Nothing in this subsection shall require coverage of duplicative
20 preventive services unless a provider determines the duplicative
21 services are clinically indicated¹. As used in this subsection,
22 "calendar year" means the 12-month period beginning January 1
23 and ending December 31] With respect to an annual wellness visit
24 for a covered member who is over three years of age, a carrier is
25 required to cover only one wellness visit per plan year or calendar
26 year, as provided for under the health benefits plan contract, but
27 may not impose a waiting period for the wellness visit².

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

29
30 8. Section 8 of P.L.2019, c.360 (C.26:2J-4.45) is amended to
31 read as follows:

32 8. a. A health maintenance organization contract that provides
33 hospital or medical expense benefits and is delivered, issued,
34 executed or renewed in this State, or approved for issuance or
35 renewal in this State by the Commissioner of Banking and
36 Insurance, on or after the effective date of this act, shall provide
37 coverage, without requiring any cost sharing, for the following
38 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;

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

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

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

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

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

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

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

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

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

32 d. The provisions of this section shall apply to those contracts
33 in which the health maintenance organization has reserved the right
34 to change the premium.

35 e. ²[A contract shall provide coverage for preventive services
36 that are recommended on an annual basis at least once per calendar
37 year, without requiring any waiting period ¹, except the contract
38 may require a waiting period that is medically necessary to ensure
39 the safety of the services¹. ¹[This requirement shall not be
40 construed to add any limitation to the frequency of coverage for
41 preventive services]

42 Nothing in this subsection shall require coverage of duplicative
43 preventive services unless a provider determines the duplicative
44 services are clinically indicated¹. As used in this subsection,
45 "calendar year" means the 12-month period beginning January 1
46 and ending December 31] With respect to an annual wellness visit
47 for a covered member who is over three years of age, a carrier is
48 required to cover only one wellness visit per plan year or calendar

1 year, as provided for under the health benefits plan contract, but
2 may not impose a waiting period for the wellness visit².

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

4
5 9. Section 9 of P.L.2019, c.360 (C.52:14-17.29dd) is amended
6 to read as follows:

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

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

15 (2) immunizations that have in effect a recommendation from
16 the Advisory Committee on Immunization Practices of the Centers
17 for Disease Control and Prevention;

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.

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

d. ²[A contract shall provide coverage for preventive services that are recommended on an annual basis at least once per calendar year, without requiring any waiting period ¹, except the contract may require a waiting period that is medically necessary to ensure the safety of the services¹. ¹[This requirement shall not be construed to add any limitation to the frequency of coverage for preventive services]

Nothing in this subsection shall require coverage of duplicative preventive services unless a provider determines the duplicative services are clinically indicated¹. As used in this subsection, "calendar year" means the 12-month period beginning January 1 and ending December 31.] With respect to an annual wellness visit for a covered member who is over three years of age, a contract is required to cover only one wellness visit per plan year or calendar year, as provided for under the contract, but may not impose a waiting period for the wellness visit².

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

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

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

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

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

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

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

b. (1) Except as provided in paragraph (2) of this subsection, 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. ²[A contract shall provide coverage for preventive services
27 that are recommended on an annual basis at least once per calendar
28 year, without requiring any waiting period ¹, except the contract
29 may require a waiting period that is medically necessary to ensure
30 the safety of the services¹. ¹[This requirement shall not be
31 construed to add any limitation to the frequency of coverage for
32 preventive services]

33 Nothing in this subsection shall require coverage of duplicative
34 preventive services unless a provider determines the duplicative
35 services are clinically indicated¹. As used in this subsection,
36 "calendar year" means the 12-month period beginning January 1
37 and ending December 31.] With respect to an annual wellness visit
38 for a covered member who is over three years of age, a contract is
39 required to cover only one wellness visit per plan year or calendar
40 year, as provided for under the contract, but may not impose a
41 waiting period for the wellness visit².

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

43
44 11. This act shall take effect on ²[the 90th day next following
45 enactment] January 1, 2027² and shall apply to policies or contracts
46 issued or renewed on or after the effective date.

1 _____
2
3 Requires certain wellness visits to be covered once per year
4 without waiting periods.