

[First Reprint]

SENATE, No. 4148

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED FEBRUARY 25, 2025

Sponsored by:

Senator JOHN J. BURZICHELLI

District 3 (Cumberland, Gloucester and Salem)

Senator ANGELA V. MCKNIGHT

District 31 (Hudson)

Co-Sponsored by:

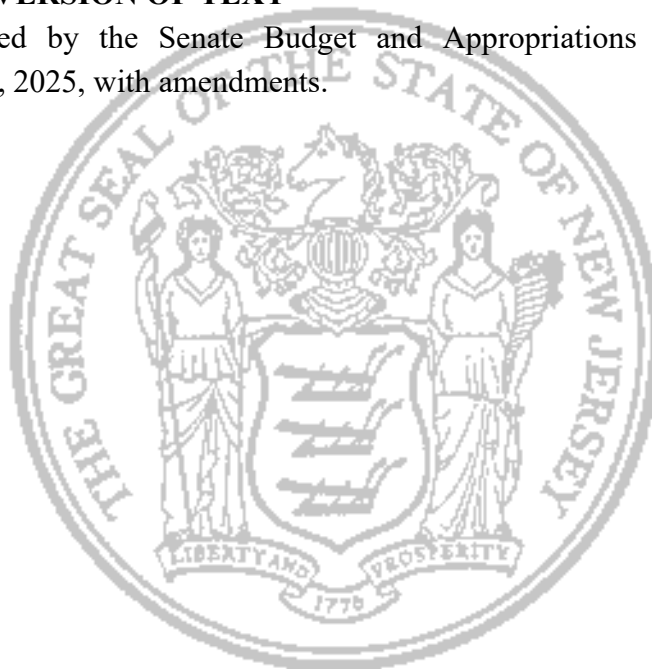
Senators Burgess and Ruiz

SYNOPSIS

Establishes “New Jersey Menopause Coverage Act”; requires health insurance coverage of medically necessary perimenopause and menopause treatments.

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on December 15, 2025, with amendments.



(Sponsorship Updated As Of: 12/18/2025)

1 AN ACT concerning health insurance coverage of certain
2 perimenopause and menopause services and amending and
3 supplementing 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. (New section) a. A hospital service corporation contract
9 that provides hospital or medical expense benefits and is delivered,
10 issued, executed or renewed in this State pursuant to P.L.1938,
11 c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in
12 this State by the Commissioner of Banking and Insurance on or
13 after the effective date of P.L. , c. (C.) (pending before the
14 Legislature as this bill), shall provide benefits to any named
15 subscriber or other person covered thereunder for expenses incurred
16 in obtaining medically necessary treatment for ¹women with a
17 diagnosis of¹ perimenopause, menopause, and symptoms associated
18 with perimenopause and menopause, including but not limited to:

19 (1) hormonal therapies such as hormone replacement therapy
20 and bioidentical hormone treatments;

21 (2) non-hormonal treatments, including medications to manage
22 perimenopause and menopausal symptoms;

23 (3) behavioral health care services;

24 (4) pelvic floor physical therapy;

25 (5) bone health treatments, including screenings¹[,] and¹
26 medications ¹[,] and supplements,¹ due to hormonal changes
27 related to perimenopause and menopause;

28 (6) preventative services that have a rating of “A” or “B” in the
29 current recommendations of the United States Preventive Services
30 Task Force¹ for early detection and treatment of health conditions
31 related to perimenopause and menopause such as ¹[,] cardiovascular
32 disease,¹ osteoporosis¹[,] and cancer; and

33 (7) counseling regarding menopause management.

34 b. A hospital service corporation shall provide clear and
35 accessible information to subscribers or covered persons regarding
36 covered perimenopause and menopause treatments.

37 c. The benefits shall be provided to the same extent as for any
38 other medical condition under the contract.

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

42 e. As used in this section:

43 “Menopause” means the ¹[,] natural and¹ permanent end of a
44 female’s menstrual cycle, diagnosed by a licensed medical provider
45 after 12 consecutive months without a menstrual period.

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:

¹Senate SBA committee amendments adopted December 15, 2025.

1 “Perimenopause” means the transitional period leading to
2 menopause, marked by fluctuating hormone levels and changes in
3 menstrual cycles.

4
5 2. (New section) a. Every medical service corporation
6 contract that provides hospital or medical expense benefits and is
7 delivered, issued, executed or renewed in this State pursuant to
8 P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or
9 renewal in this State by the Commissioner of Banking and
10 Insurance on or after the effective date of P.L. , c. (C.)
11 (pending before the Legislature as this bill), shall provide benefits
12 to any named subscriber or other person covered thereunder for
13 expenses incurred in obtaining medically necessary treatment for
14 ‘women with a diagnosis of’ perimenopause, menopause, and
15 symptoms associated with perimenopause and menopause,
16 including but not limited to:

17 (1) hormonal therapies such as hormone replacement therapy
18 and bioidentical hormone treatments;

19 (2) non-hormonal treatments, including medications to manage
20 menopausal symptoms;

21 (3) behavioral health care services;

22 (4) pelvic floor physical therapy;

23 (5) bone health treatments, including screenings¹[,] and¹
24 medications ¹[,] and supplements,¹ due to hormonal changes
25 related to perimenopause and menopause;

26 (6) preventative services ‘that have a rating of “A” or “B” in the
27 current recommendations of the United States Preventive Services
28 Task Force’ for early detection and treatment of health conditions
29 related to perimenopause and menopause such as ¹[,] cardiovascular
30 disease,¹ osteoporosis¹[,] and cancer; and

31 (7) counseling and education regarding menopause
32 management.

33 b. A medical service corporation shall provide clear and
34 accessible information to subscribers or covered persons regarding
35 covered perimenopause and menopause treatments.

36 c. The benefits shall be provided to the same extent as for any
37 other medical condition under the contract.

38 d. The provisions of this section shall apply to all medical
39 service corporation contracts in which the medical service
40 corporation has reserved the right to change the premium.

41 e. As used in this section:

42 “Menopause” means the ¹[,] natural and¹ permanent end of a
43 female’s menstrual cycle, diagnosed by a licensed medical provider
44 after 12 consecutive months without a menstrual period.

45 “Perimenopause” means the transitional period leading to
46 menopause, marked by fluctuating hormone levels and changes in
47 menstrual cycles.

1 3. (New section) a. Every health service corporation contract
2 that provides hospital or medical expense benefits and is delivered,
3 issued, executed or renewed in this State pursuant to P.L.1985,
4 c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in
5 this State by the Commissioner of Banking and Insurance on or
6 after the effective date of P.L. , c. (C.) (pending before the
7 Legislature as this bill), shall provide benefits to any named
8 subscriber or other person covered thereunder for expenses incurred
9 in obtaining medically necessary treatment for 1women with a
10 diagnosis of¹ perimenopause, menopause, and symptoms associated
11 with perimenopause and menopause, including but not limited to:

12 (1) hormonal therapies such as hormone replacement therapy
13 and bioidentical hormone treatments;

14 (2) non-hormonal treatments, including medications to manage
15 menopausal symptoms;

16 (3) behavioral health care services;

17 (4) pelvic floor physical therapy;

18 (5) bone health treatments, including screenings¹**[,]** and¹
19 medications ¹**[,]** and supplements,¹ due to hormonal changes
20 related to perimenopause and menopause;

21 (6) preventative services 1that have a rating of “A” or “B” in the
22 current recommendations of the United States Preventive Services
23 Task Force¹ for early detection and treatment of health conditions
24 related to perimenopause and menopause such as ¹**[cardiovascular**
25 **disease,]**¹ osteoporosis¹**[,]**¹ and cancer; and

26 (7) counseling and education regarding menopause
27 management.

28 b. A health service corporation shall provide clear and
29 accessible information to subscribers or covered persons regarding
30 covered perimenopause and menopause treatments.

31 c. The benefits shall be provided to the same extent as for any
32 other medical condition under the contract.

33 d. The provisions of this section shall apply to all health
34 service corporation contracts in which the health service
35 corporation has reserved the right to change the premium.

36 e. As used in this section:

37 “Menopause” means the ¹**[natural and]**¹ permanent end of a
38 female’s menstrual cycle, diagnosed by a licensed medical provider
39 after 12 consecutive months without a menstrual period.

40 “Perimenopause” means the transitional period leading to
41 menopause, marked by fluctuating hormone levels and changes in
42 menstrual cycles.

43
44 4. (New section) a. Every individual policy that provides
45 hospital or medical expense benefits and is delivered, issued,
46 executed or renewed in this State pursuant to N.J.S. 17B:26-1 et
47 seq., or approved for issuance or renewal in this State by the
48 Commissioner of Banking and Insurance on or after the effective

1 date of P.L. , c. (C.) (pending before the Legislature as this
2 bill), shall provide benefits to any named insured or other person
3 covered thereunder for expenses incurred in obtaining medically
4 necessary treatment for 1women with a diagnosis of1
5 perimenopause, menopause, and symptoms associated with
6 perimenopause and menopause, including but not limited to:

7 (1) hormonal therapies such as hormone replacement therapy
8 and bioidentical hormone treatments;

9 (2) non-hormonal treatments, including medications to manage
10 menopausal symptoms;

11 (3) behavioral health care services;

12 (4) pelvic floor physical therapy;

13 (5) bone health treatments, including screenings¹ and¹
14 medications ¹, and supplements,¹ due to hormonal changes
15 related to perimenopause and menopause;

16 (6) preventative services 1that have a rating of “A” or “B” in the
17 current recommendations of the United States Preventive Services
18 Task Force1 for early detection and treatment of health conditions
19 related to perimenopause and menopause such as ¹cardiovascular
20 disease,¹ osteoporosis¹ and cancer; and

21 (7) counseling and education regarding menopause
22 management.

23 b. Every individual policy shall provide clear and accessible
24 information to insureds regarding covered perimenopause and
25 menopause treatments.

26 c. The benefits shall be provided to the same extent as for any
27 other medical condition under the policy.

28 d. The provisions of this section shall apply to all health
29 insurance policies in which the insurer has reserved the right to
30 change the premium.

31 e. As used in this section:

32 “Menopause” means the ¹natural and¹ permanent end of a
33 female’s menstrual cycle, diagnosed by a licensed medical provider
34 after 12 consecutive months without a menstrual period.

35 “Perimenopause” means the transitional period leading to
36 menopause, marked by fluctuating hormone levels and changes in
37 menstrual cycles.

38

39 5. (New section) a. Every group health policy that provides
40 hospital or medical expense benefits and is delivered, issued,
41 executed or renewed in this State pursuant to N.J.S.17B:27-26 et
42 seq., or approved for issuance or renewal in this State by the
43 Commissioner of Banking and Insurance on or after the effective
44 date of P.L. , c. (C.) (pending before the Legislature as this
45 bill), shall provide benefits to any named insured or other person
46 covered thereunder for expenses incurred in obtaining medically
47 necessary treatment for 1women with a diagnosis of1

1 perimenopause, menopause, and symptoms associated with
2 perimenopause and menopause, including but not limited to:

3 (1) hormonal therapies such as hormone replacement therapy
4 and bioidentical hormone treatments;

5 (2) non-hormonal treatments, including medications to manage
6 menopausal symptoms;

7 (3) behavioral health care services;

8 (4) pelvic floor physical therapy;

9 (5) bone health treatments, including screenings¹[,] and¹
10 medications ¹[, and supplements,¹ due to hormonal changes
11 related to perimenopause and menopause;

12 (6) preventative services ¹that have a rating of “A” or “B” in the
13 current recommendations of the United States Preventive Services
14 Task Force¹ for early detection and treatment of health conditions
15 related to perimenopause and menopause such as ¹[cardiovascular
16 disease,¹ osteoporosis¹[,] and cancer; and

17 (7) counseling and education regarding menopause
18 management.

19 b. Every group policy shall provide clear and accessible
20 information to insureds regarding covered perimenopause and
21 menopause treatments.

22 c. The benefits shall be provided to the same extent as for any
23 other medical condition under the policy.

24 d. The provisions of this section shall apply to all policies in
25 which the insurer has reserved the right to change the premium.

26 e. As used in this section:

27 “Menopause” means the ¹[natural and¹] permanent end of a
28 female’s menstrual cycle, diagnosed by a licensed medical provider
29 after 12 consecutive months without a menstrual period.

30 “Perimenopause” means the transitional period leading to
31 menopause, marked by fluctuating hormone levels and changes in
32 menstrual cycles.

33

34 6. (New section) a. Every enrollee agreement that provides
35 hospital or medical expense benefits and is delivered, issued,
36 executed or renewed in this State pursuant to P.L.1973, c.337
37 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State
38 by the Commissioner of Banking and Insurance on or after the
39 effective date of P.L. , c. (C.) (pending before the
40 Legislature as this bill), shall provide benefits to any enrollee or
41 other person covered thereunder for expenses incurred in obtaining
42 medically necessary treatment ¹[related to] for women with a
43 diagnosis of¹ perimenopause and menopause, including but not
44 limited to:

45 (1) hormonal therapies such as hormone replacement therapy
46 and bioidentical hormone treatments;

47 (2) non-hormonal treatments, including medications to manage
48 menopausal symptoms;

- 1 (3) behavioral health care services;
- 2 (4) pelvic floor physical therapy;
- 3 (5) bone health treatments, including screenings¹ and¹
- 4 medications ¹, and supplements,¹ due to hormonal changes
- 5 related to perimenopause and menopause;
- 6 (6) preventative services ¹that have a rating of “A” or “B” in the
- 7 current recommendations of the United States Preventive Services
- 8 Task Force¹ for early detection and treatment of health conditions
- 9 related to perimenopause and menopause such as ¹cardiovascular
- 10 disease,¹ osteoporosis¹, and cancer; and
- 11 (7) counseling and education regarding menopause
- 12 management.
- 13 b. A health maintenance organization shall provide clear and
- 14 accessible information to enrollees regarding covered
- 15 perimenopause and menopause treatments.
- 16 c. The benefits shall be provided to the same extent as for any
- 17 other medical condition under the enrollee agreement.
- 18 d. The provisions of this section shall apply to all enrollee
- 19 agreements in which the health maintenance organization has
- 20 reserved the right to change the schedule of charges.
- 21 e. As used in this section:
- 22 “Menopause” means the ¹natural and¹ permanent end of a
- 23 female’s menstrual cycle, diagnosed by a licensed medical provider
- 24 after 12 consecutive months without a menstrual period.
- 25 “Perimenopause” means the transitional period leading to
- 26 menopause, marked by fluctuating hormone levels and changes in
- 27 menstrual cycles.
- 28
- 29 7. (New section) a. Every individual health benefits plan that
- 30 provides hospital or medical expense benefits and is delivered,
- 31 issued, executed or renewed in this State pursuant to P.L.1992,
- 32 c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in
- 33 this State by the Commissioner of Banking and Insurance on or
- 34 after the effective date of P.L. , c. (C.) (pending before the
- 35 Legislature as this bill), shall provide benefits to any person
- 36 covered thereunder for expenses incurred in obtaining medically
- 37 necessary treatment for ¹women with a diagnosis of¹
- 38 perimenopause, menopause, and symptoms associated with
- 39 perimenopause and menopause, including but not limited to:
- 40 (1) hormonal therapies such as hormone replacement therapy
- 41 and bioidentical hormone treatments;
- 42 (2) non-hormonal treatments, including medications to manage
- 43 menopausal symptoms;
- 44 (3) behavioral health care services;
- 45 (4) pelvic floor physical therapy;
- 46 (5) bone health treatments, including screenings¹ and¹
- 47 medications ¹, and supplements,¹ due to hormonal changes
- 48 related to perimenopause and menopause;

- 1 (6) preventative services ¹that have a rating of “A” or “B” in the
2 current recommendations of the United States Preventive Services
3 Task Force¹ for early detection and treatment of health conditions
4 related to perimenopause and menopause such as ¹[cardiovascular
5 disease,]¹ osteoporosis¹[,]¹ and cancer; and
- 6 (7) counseling and education regarding menopause
7 management.
- 8 b. An individual health benefits plan shall provide clear and
9 accessible information to a covered person regarding covered
10 perimenopause and menopause treatments.
- 11 c. The benefits shall be provided to the same extent as for any
12 other medical condition under the health benefits plan.
- 13 d. The provisions of this section shall apply to all enrollee
14 agreements in which the insurer has reserved the right to change the
15 premium.
- 16 e. As used in this section:
- 17 “Menopause” means the ¹[natural and]¹ permanent end of a
18 female’s menstrual cycle, diagnosed by a licensed medical provider
19 after 12 consecutive months without a menstrual period.
- 20 “Perimenopause” means the transitional period leading to
21 menopause, marked by fluctuating hormone levels and changes in
22 menstrual cycles.
- 23
- 24 8. (New section) a. Every small employer health benefits plan
25 that provides hospital or medical expense benefits and is delivered,
26 issued, executed or renewed in this State pursuant to P.L.1992,
27 c.162 (C.17B:27A-17 et seq.), or approved for issuance or renewal
28 in this State by the Commissioner of Banking and Insurance on or
29 after the effective date of P.L. , c. (C.) (pending before the
30 Legislature as this bill), shall provide benefits to any person
31 covered thereunder for expenses incurred in obtaining medically
32 necessary treatment for ¹women with a diagnosis of¹
33 perimenopause, menopause, and symptoms associated with
34 perimenopause and menopause, including but not limited to:
- 35 (1) hormonal therapies such as hormone replacement therapy
36 and bioidentical hormone treatments;
- 37 (2) non-hormonal treatments, including medications to manage
38 menopausal symptoms;
- 39 (3) behavioral health care services;
- 40 (4) pelvic floor physical therapy;
- 41 (5) bone health treatments, including screenings¹[,]¹ and¹
42 medications ¹[, and supplements,]¹ due to hormonal changes
43 related to perimenopause and menopause;
- 44 (6) preventative services ¹that have a rating of “A” or “B” in the
45 current recommendations of the United States Preventive Services
46 Task Force¹ for early detection and treatment of health conditions
47 related to perimenopause and menopause such as ¹[cardiovascular
48 disease,]¹ osteoporosis¹[,]¹ and cancer; and

1 (7) counseling and education regarding menopause
2 management.

3 b. A small employer health benefits plan shall provide clear
4 and accessible information to a covered person regarding covered
5 perimenopause and menopause treatments.

6 c. The benefits shall be provided to the same extent as for any
7 other medical condition under the health benefits plan.

8 d. The provisions of this section shall apply to all enrollee
9 agreements in which the insurer has reserved the right to change the
10 premium.

11 e. As used in this section:

12 “Menopause” means the ¹ [natural and] ¹ permanent end of a
13 female’s menstrual cycle, diagnosed by a licensed medical provider
14 after 12 consecutive months without a menstrual period.

15 “Perimenopause” means the transitional period leading to
16 menopause, marked by fluctuating hormone levels and changes in
17 menstrual cycles.

18

19 9. (New section) a. The State Health Benefits Commission
20 shall ensure that every contract purchased by the commission on or
21 after the effective date of P.L. , c. (C.) (pending before the
22 Legislature as this bill), that provides hospital or medical expense
23 benefits, shall provide benefits to any person covered thereunder for
24 expenses incurred in obtaining medically necessary treatment for
25 1 women with a diagnosis of ¹ perimenopause, menopause, and
26 symptoms associated with perimenopause and menopause,
27 including but not limited to:

28 (1) hormonal therapies such as hormone replacement therapy
29 and bioidentical hormone treatments;

30 (2) non-hormonal treatments, including medications to manage
31 menopausal symptoms;

32 (3) behavioral health care services;

33 (4) pelvic floor physical therapy;

34 (5) bone health treatments, including screenings ¹ [,] and¹
35 medications ¹ [,] and supplements, ¹ due to hormonal changes
36 related to perimenopause and menopause;

37 (6) preventative services 1 that have a rating of “A” or “B” in the
38 current recommendations of the United States Preventive Services
39 Task Force¹ for early detection and treatment of health conditions
40 related to perimenopause and menopause such as ¹ [cardiovascular
41 disease,] ¹ osteoporosis ¹ [,] ¹ and cancer; and

42 (7) counseling and education regarding menopause
43 management.

44 b. The State Health Benefits Commission shall ensure that each
45 contract shall provide clear and accessible information to a covered
46 person regarding covered perimenopause and menopause
47 treatments.

1 c. The benefits shall be provided to the same extent as for any
2 other medical condition under the contract.

3 d. As used in this section:

4 “Menopause” means the ¹[natural and]¹ permanent end of a
5 female’s menstrual cycle, diagnosed by a licensed medical provider
6 after 12 consecutive months without a menstrual period.

7 “Perimenopause” means the transitional period leading to
8 menopause, marked by fluctuating hormone levels and changes in
9 menstrual cycles.

10

11 10. (New section) a. The School Employees’ Health Benefits
12 Commission shall ensure that every contract purchased by the
13 commission on or after the effective date of P.L. , c. (C.)
14 (pending before the Legislature as this bill), that provides hospital
15 or medical expense benefits, shall provide benefits to any person
16 covered thereunder for expenses incurred in obtaining medically
17 necessary treatment for ¹women with a diagnosis of¹
18 perimenopause, menopause, and symptoms associated with
19 perimenopause and menopause, including but not limited to:

20 (1) hormonal therapies such as hormone replacement therapy
21 and bioidentical hormone treatments;

22 (2) non-hormonal treatments, including medications to manage
23 menopausal symptoms;

24 (3) behavioral health care services;

25 (4) pelvic floor physical therapy;

26 (5) bone health treatments, including screenings¹[.] and¹
27 medications ¹[,] and supplements,¹ due to hormonal changes
28 related to perimenopause and menopause;

29 (6) preventative services ¹that have a rating of “A” or “B” in the
30 current recommendations of the United States Preventive Services
31 Task Force¹ for early detection and treatment of health conditions
32 related to perimenopause and menopause such as ¹[cardiovascular
33 disease,]¹ osteoporosis¹[,]¹ and cancer; and

34 (7) counseling and education regarding menopause
35 management.

36 b. The School Employees Health Benefits Commission shall
37 ensure that each contract shall provide clear and accessible
38 information to a covered person regarding covered perimenopause
39 and menopause treatments.

40 c. The benefits shall be provided to the same extent as for any
41 other medical condition under the contract.

42 d. As used in this section:

43 “Menopause” means the ¹[natural and]¹ permanent end of a
44 female’s menstrual cycle, diagnosed by a licensed medical provider
45 after 12 consecutive months without a menstrual period.

46 “Perimenopause” means the transitional period leading to
47 menopause, marked by fluctuating hormone levels and changes in
48 menstrual cycles.

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

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

- 8 (1) Inpatient hospital services
- 9 (2) Outpatient hospital services;
- 10 (3) Other laboratory and X-ray services;
- 11 (4) (a) Skilled nursing or intermediate care facility services;
- 12 (b) Early and periodic screening and diagnosis of individuals
13 who are eligible under the program and are under age 21, to
14 ascertain their physical or mental health status and the health care,
15 treatment, and other measures to correct or ameliorate defects and
16 chronic conditions discovered thereby, as may be provided in
17 regulation of the Secretary of the federal Department of Health and
18 Human Services and approved by the commissioner;
- 19 (5) Physician's services furnished in the office, the patient's
20 home, a hospital, a skilled nursing, or intermediate care facility or
21 elsewhere.

22 As used in this subsection, "laboratory and X-ray services"
23 includes HIV drug resistance testing, including, but not limited to,
24 genotype assays that have been cleared or approved by the federal
25 Food and Drug Administration, laboratory developed genotype
26 assays, phenotype assays, and other assays using phenotype
27 prediction with genotype comparison, for persons diagnosed with
28 HIV infection or AIDS.

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

- 33 (1) Medical care not included in subsection a.(5) above, or any
34 other type of remedial care recognized under State law, furnished
35 by licensed practitioners within the scope of their practice, as
36 defined by State law;
- 37 (2) Home health care services;
- 38 (3) Clinic services;
- 39 (4) Dental services;
- 40 (5) Physical therapy and related services;
- 41 (6) Prescribed drugs, dentures, and prosthetic devices; and
42 eyeglasses prescribed by a physician skilled in diseases of the eye
43 or by an optometrist, whichever the individual may select;
- 44 (7) Optometric services;
- 45 (8) Podiatric services;
- 46 (9) Chiropractic services;
- 47 (10) Psychological services;

- 1 (11) Inpatient psychiatric hospital services for individuals under
2 21 years of age, or under age 22 if they are receiving such services
3 immediately before attaining age 21;
- 4 (12) Other diagnostic, screening, preventative, and rehabilitative
5 services, and other remedial care;
- 6 (13) Inpatient hospital services, nursing facility services, and
7 immediate care facility services for individuals 65 years of age or
8 over in an institution for mental diseases;
- 9 (14) Intermediate care facility services;
- 10 (15) Transportation services;
- 11 (16) Services in connection with the inpatient or outpatient
12 treatment or care of substance use disorder, when the treatment is
13 prescribed by a physician and provided in a licensed hospital or in a
14 narcotic and substance use disorder treatment center approved by
15 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
16 et. seq.) and whose staff includes a medical director, and limited
17 those services eligible for federal financial participation under Title
18 XIX of the federal Social Security Act;
- 19 (17) Any other medical care and any other type of remedial care
20 recognized under State law, specified by the Secretary of the federal
21 Department of Health and Human Services, and approved by the
22 commissioner;
- 23 (18) Comprehensive maternity care, which may include: the
24 basic number of prenatal and postpartum visits recommended by the
25 American College of Obstetrics and Gynecology; additional
26 prenatal and postpartum visits that are medically necessary;
27 necessary laboratory, nutritional assessment and counseling, health
28 education, personal counseling, managed care, outreach, and
29 follow-up services; treatment of conditions which may complicate
30 pregnancy doula care; and physician or certified nurse midwife
31 delivery services. For the purposes of this paragraph, "doula"
32 means a trained professional who provides continuous physical,
33 emotional, and informational support to a mother before, during,
34 and shortly after childbirth, to help her to achieve the healthiest,
35 most satisfying experience possible;
- 36 (19) Comprehensive pediatric care, which may include:
37 ambulatory, preventive, and primary care health services. The
38 preventive services shall include, at a minimum, the basic number
39 of preventive visits recommended by the American Academy of
40 Pediatrics;
- 41 (20) Services provided by a hospice which is participating in the
42 Medicare program established pursuant to Title XVIII of the Social
43 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
44 services shall be provided subject to approval of the Secretary of
45 the federal Department of Health and Human Services for federal
46 reimbursement;
- 47 (21) Mammograms, subject to approval of the Secretary of the
48 federal Department of Health and Human Services for federal
49 reimbursement, including one baseline mammogram for women

1 who are at least 35 but less than 40 years of age; one mammogram
2 examination every two years or more frequently, if recommended
3 by a physician, for women who are at least 40 but less than 50 years
4 of age; and one mammogram examination every year for women
5 age 50 and over;

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

10 (a) Expenses for diabetes self-management education or training
11 to ensure that a person with diabetes, gestational diabetes, or pre-
12 diabetes can optimize metabolic control, prevent and manage
13 complications, and maximize quality of life. Diabetes self-
14 management education shall be provided by an in-State provider
15 who is:

16 (i) a licensed, registered, or certified health care professional
17 who is certified by the National Certification Board of Diabetes
18 Educators as a Certified Diabetes Educator, or certified by the
19 American Association of Diabetes Educators with a Board
20 Certified-Advanced Diabetes Management credential, including, but
21 not limited to: a physician, an advanced practice or registered nurse,
22 a physician assistant, a pharmacist, a chiropractor, a dietitian
23 registered by a nationally recognized professional association of
24 dietitians, or a nutritionist holding a certified nutritionist specialist
25 (CNS) credential from the Board for Certification of Nutrition
26 Specialists; or

27 (ii) an entity meeting the National Standards for Diabetes Self-
28 Management Education and Support, as evidenced by a recognition
29 by the American Diabetes Association or accreditation by the
30 American Association of Diabetes Educators;

31 (b) Expenses for medical nutrition therapy as an effective
32 component of the person's overall treatment plan upon a: diagnosis
33 of diabetes, gestational diabetes, or pre-diabetes; change in the
34 beneficiary's medical condition, treatment, or diagnosis; or
35 determination of a physician, advanced practice nurse, or physician
36 assistant that reeducation or refresher education is necessary.
37 Medical nutrition therapy shall be provided by an in-State provider
38 who is a dietitian registered by a nationally-recognized professional
39 association of dietitians, or a nutritionist holding a certified
40 nutritionist specialist (CNS) credential from the Board for
41 Certification of Nutrition Specialists, who is familiar with the
42 components of diabetes medical nutrition therapy;

43 (c) For a person diagnosed with pre-diabetes, items and services
44 furnished under an in-State diabetes prevention program that meets
45 the standards of the National Diabetes Prevention Program, as
46 established by the federal Centers for Disease Control and
47 Prevention; and

48 (d) Expenses for any medically appropriate and necessary
49 supplies and equipment recommended or prescribed by a physician,

1 advanced practice nurse, or physician assistant for the management
2 and treatment of diabetes, gestational diabetes, or pre-diabetes,
3 including, but not limited to: equipment and supplies for self-
4 management of blood glucose; insulin pens; insulin pumps and
5 related supplies; and other insulin delivery devices;

6 (23) Expenses incurred for the provision of group prenatal
7 services to a pregnant woman, provided that:

8 (a) the provider of such services, which shall include, but not be
9 limited to, a federally qualified health center or a community health
10 center operating in the State:

11 (i) is a site accredited by the Centering Healthcare Institute, or is
12 a site engaged in an active implementation contract with the
13 Centering Healthcare institute, that utilizes the Centering Pregnancy
14 model; and

15 (ii) incorporates the applicable information outlined in any best
16 practices manual for prenatal and postpartum maternal care
17 developed by the Department of Health into the curriculum for each
18 group prenatal visit;

19 (b) each group prenatal care visit is at least 1.5 hours in duration,
20 with a minimum of two women and a maximum of 20 women in
21 participation; and

22 (c) no more than 10 group prenatal care visits occur per
23 pregnancy. As used in this paragraph, "group prenatal care
24 services" means a series of prenatal care visits provided in a group
25 setting which are based upon the Centering Pregnancy model
26 developed by the Centering Healthcare Institute and which include
27 health assessments, social and clinical support, and educational
28 activities;

29 (24) Expenses incurred for the provision of pasteurized donated
30 human breast milk, which shall include human milk fortifiers if
31 indicated in a medical order provided by a licensed medical
32 practitioner, to an infant under the age of six months; provided that
33 the milk is obtained from a human milk bank that meets quality
34 guidelines established by the Department of Health and a licensed
35 medical practitioner has issued a medical order for the infant under
36 at least one of the following circumstances:

37 (a) the infant is medically or physically unable to receive
38 maternal breast milk or participate in breast feeding, or the infant's
39 mother is medically or physically unable to produce maternal breast
40 milk in sufficient quantities or participate in breast feeding despite
41 optimal lactation support; or

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

43 (i) a body weight below healthy levels, as determined by the
44 licensed medical practitioner issuing the medical order for the
45 infant;

46 (ii) the infant has a congenital or acquired condition that places
47 the infant at a high risk for development of necrotizing
48 enterocolitis; or

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

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

15 (a) Information regarding the availability of the tobacco
16 cessation services described in this paragraph shall be provided to
17 all individuals authorized to receive the tobacco cessation services
18 pursuant to this paragraph at the following times: no later than 90
19 days after the effective date of P.L.2019, c.473: upon the
20 establishment of an individual's eligibility for medical assistance;
21 and upon the redetermination of an individual's eligibility for
22 medical assistance;

23 (b) The following conditions shall not be imposed on any
24 tobacco cessation services provided pursuant to this paragraph:
25 copayments or any other forms of cost-sharing, including
26 deductibles; counseling requirements for medication; stepped care
27 therapy or similar restrictions requiring the use of one service prior
28 to another; limits on the duration of services; or annual or lifetime
29 limits on the amount, frequency, or cost of services, including, but
30 not limited to, annual or lifetime limits on the number of covered
31 attempts to quit; and

32 (c) Prior authorization requirements shall not be imposed on any
33 tobacco cessation services provided pursuant to this paragraph
34 except in the following circumstances where prior authorization
35 may be required: for a treatment that exceeds the duration
36 recommended by the most recently published United States Public
37 Health Service clinical practice guidelines on treating tobacco use
38 and dependence; or for services associated with more than two
39 attempts to quit within a 12-month period;

40 (26) Provided that there is federal financial participation
41 available, benefits for expenses incurred in conducting a colorectal
42 cancer screening in accordance with United States Preventive
43 Services Task Force recommendations. The method and frequency
44 of screening to be utilized shall be in accordance with the most
45 recent published recommendations of the United States Preventive
46 Services Task Force and as determined medically necessary by the
47 covered person's physician, in consultation with the covered person.

48 No deductible, coinsurance, copayment, or any other cost-
49 sharing requirement shall be imposed for a colonoscopy performed

1 following a positive result on a non-colonoscopy, colorectal cancer
2 screening test recommended by the United States Preventive
3 Services Task Force; **[and]**

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

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

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

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

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

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

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

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

26 (iii) the Division of Medical Assistance and Health Services in
27 the Department of Human Services may include any other service
28 deemed appropriate under the benefits provided under this
29 paragraph.

30 (c) Providers authorized to deliver benefits provided under this
31 paragraph shall include Medicaid-approved licensed hospice
32 agencies, Medicaid-approved home health agencies licensed to
33 provide hospice care, and other Medicaid-approved licensed health
34 care providers.

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

38 (e) This paragraph shall not affect a beneficiary's eligibility to
39 receive, concurrently with services provided for in this paragraph,
40 any services, including home health services, for which the
41 beneficiary would have been eligible in the absence of this
42 paragraph, to the extent that services are not duplicative; and

43 (28) (a) medically necessary treatment for ¹women with a
44 diagnosis of¹ perimenopause, menopause, and symptoms associated
45 with perimenopause and menopause, including but not limited to:

46 (i) hormonal therapies such as hormone replacement therapy
47 and bioidentical hormone treatments;

48 (ii) non-hormonal treatments, including medications to manage
49 menopausal symptoms;

- 1 (iii) behavioral health care services;
2 (iv) pelvic floor physical therapy;
3 (v) bone health treatments, including screenings¹ and¹
4 medications¹, and supplements,¹ due to hormonal changes related
5 to perimenopause and menopause;
6 (vi) preventative services¹ that have a rating of “A” or “B” in the
7 current recommendations of the United States Preventive Services
8 Task Force¹ for early detection and treatment of health conditions
9 related to perimenopause and menopause such as¹ cardiovascular
10 disease,¹ osteoporosis¹ and cancer; and
11 (vii) counseling and education regarding menopause
12 management.

13 (b) Individuals receiving medical assistance shall be provided
14 with clear and accessible information regarding covered
15 perimenopause and menopause related treatments.

16 (c) As used in this paragraph:

17 “Menopause” means the¹ natural and¹ permanent end of a
18 female’s menstrual cycle, diagnosed by a licensed medical provider
19 after 12 consecutive months without a menstrual period.

20 “Perimenopause” means the transitional period leading to
21 menopause, marked by fluctuating hormone levels and changes in
22 menstrual cycles.

23 c. Payments for the foregoing services, goods and supplies
24 furnished pursuant to this act shall be made to the extent authorized
25 by this act, the rules and regulations promulgated pursuant thereto
26 and, where applicable, subject to the agreement of insurance
27 provided for under this act. The payments shall constitute payment
28 in full to the provider on behalf of the recipient. Every provider
29 making a claim for payment pursuant to this act shall certify in
30 writing on the claim submitted that no additional amount will be
31 charged to the recipient, the recipient's family, the recipient's
32 representative or others on the recipient's behalf for the services,
33 goods, and supplies furnished pursuant to this act.

34 No provider whose claim for payment pursuant to this act has
35 been denied because the services, goods, or supplies were
36 determined to be medically unnecessary shall seek reimbursement
37 from the recipient, his family, his representative or others on his
38 behalf for such services, goods, and supplies provided pursuant to
39 this act; provided, however, a provider may seek reimbursement
40 from a recipient for services, goods, or supplies not authorized by
41 this act, if the recipient elected to receive the services, goods or
42 supplies with the knowledge that they were not authorized.

43 d. Any individual eligible for medical assistance (including
44 drugs) may obtain such assistance from any person qualified to
45 perform the service or services required (including an organization
46 which provides such services, or arranges for their availability on a
47 prepayment basis), who undertakes to provide the individual such
48 services.

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

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

7 (1) Is an inmate of a public institution (except as a patient in a
8 medical institution); provided, however, that an individual who is
9 otherwise eligible may continue to receive services for the month in
10 which he becomes an inmate, should the commissioner determine to
11 expand the scope of Medicaid eligibility to include such an
12 individual, subject to the limitations imposed by federal law and
13 regulations, or

14 (2) Has not attained 65 years of age and who is a patient in an
15 institution for mental diseases, or

16 (3) Is over 21 years of age and who is receiving inpatient
17 psychiatric hospital services in a psychiatric facility; provided,
18 however, that an individual who was receiving such services
19 immediately prior to attaining age 21 may continue to receive such
20 services until the individual reaches age 22. Nothing in this
21 subsection shall prohibit the commissioner from extending medical
22 assistance to all eligible persons receiving inpatient psychiatric
23 services; provided that there is federal financial participation
24 available.

25 f. (1) A third party as defined in section 3 of P.L.1968, c.413
26 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
27 this or another state when determining the person's eligibility for
28 enrollment or the provision of benefits by that third party.

29 (2) In addition, any provision in a contract of insurance, health
30 benefits plan, or other health care coverage document, will, trust,
31 agreement, court order, or other instrument which reduces or
32 excludes coverage or payment for health care-related goods and
33 services to or for an individual because of that individual's actual or
34 potential eligibility for or receipt of Medicaid benefits shall be null
35 and void, and no payments shall be made under this act as a result
36 of any such provision.

37 (3) Notwithstanding any provision of law to the contrary, the
38 provisions of paragraph (2) of this subsection shall not apply to a
39 trust agreement that is established pursuant to 42 U.S.C.
40 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
41 provided by government entities to a person who is disabled as
42 defined in section 1614(a)(3) of the federal Social Security Act (42
43 31 U.S.C. s.1382c (a)(3)).

44 g. The following services shall be provided to eligible
45 medically needy individuals as follows:

46 (1) Pregnant women shall be provided prenatal care and delivery
47 services and postpartum care, including the services cited in
48 subsections a.(1), (3), and (5) of this section and subsections b.(1)-

1 (10), (12), (15), and (17) of this section, and nursing facility
2 services cited in subsection b.(13) of this section.

3 (2) Dependent children shall be provided with services cited in
4 subsections a.(3) and (5) of this section and subsections b.(1), (2),
5 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
6 nursing facility services cited in subsection b.(13) of this section.

7 (3) Individuals who are 65 years of age or older shall be
8 provided with services cited in subsections a.(3) and (5) of this
9 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
10 (7), (8), (10), (12), (15), and (17) of this section, and nursing
11 facility services cited in subsection b.(13) of this section.

12 (4) Individuals who are blind or disabled shall be provided with
13 services cited in subsections a.(3) and (5) of this section and
14 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
15 (12), (15), and (17) of this section, and nursing facility services
16 cited in subsection b.(13) of this section.

17 (5) (a) Inpatient hospital services, subsection a.(1) of this
18 section, shall only be provided to eligible medically needy
19 individuals, other than pregnant women, if the federal Department
20 of Health and Human Services discontinues the State's waiver to
21 establish inpatient hospital reimbursement rates for the Medicare
22 and Medicaid programs under the authority of section 601(c)(3) of
23 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
24 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
25 extended to other eligible medically needy individuals if the federal
26 Department of Health and Human Services directs that these
27 services be included.

28 (b) Outpatient hospital services, subsection a.(2) of this section,
29 shall only be provided to eligible medically needy individuals if the
30 federal Department of Health and Human Services discontinues the
31 State's waiver to establish outpatient hospital reimbursement rates
32 for the Medicare and Medicaid programs under the authority of
33 section 601(c)(3) of the Social Security Amendments of 1983,
34 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
35 services may be extended to all or to certain medically needy
36 individuals if the federal Department of Health and Human Services
37 directs that these services be included. However, the use of
38 outpatient hospital services shall be limited to clinic services and to
39 emergency room services for injuries and significant acute medical
40 conditions.

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

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

48 i. In the case of a specified low-income Medicare beneficiary
49 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical

1 assistance provided under this act shall be the payment of premiums
2 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
3 U.S.C. s.1396d(p)(3)(A)(ii).

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

9 k. In the case of a qualified individual pursuant to 42 U.S.C.
10 s.1396a(ii), the only medical assistance provided under this act shall
11 be payment for family planning services and supplies as described
12 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
13 treatment services that are provided pursuant to a family planning
14 service in a family planning setting.

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

16

17 12. This act shall take effect on the 90th day next following
18 enactment and shall apply to policies and contracts that are
19 delivered, issued, executed or renewed on or after that date¹, except
20 that policies and contracts that are delivered, issued, executed or
21 renewed pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall be
22 effective on January 1, 2027¹.