

[Second Reprint]

**ASSEMBLY, No. 5785**

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**STATE OF NEW JERSEY**

**221st LEGISLATURE**

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INTRODUCED JUNE 16, 2025

**Sponsored by:**

**Assemblywoman HEATHER SIMMONS**  
**District 3 (Cumberland, Gloucester and Salem)**  
**Senator JOHN J. BURZICHELLI**  
**District 3 (Cumberland, Gloucester and Salem)**  
**Senator ANGELA V. MCKNIGHT**  
**District 31 (Hudson)**

**SYNOPSIS**

Requires certain wellness visits to be covered once per year without waiting periods.

**CURRENT VERSION OF TEXT**

As reported by the Senate Budget and Appropriations Committee on January 8, 2026, with amendments.



**(Sponsorship Updated As Of: 1/12/2026)**

1    **AN ACT** concerning <sup>2</sup>**【preventive services】 annual wellness visits<sup>2</sup>**  
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.

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

**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:**

<sup>1</sup>**Assembly AFI committee amendments adopted December 11, 2025.**

<sup>2</sup>**Senate SBA committee amendments adopted January 8, 2026.**

1       c. (1) A contract 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 contract 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. The provisions of this section shall apply to those hospital  
15 service corporation contracts in which the hospital service  
16 corporation has reserved the right to change the premium.

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

24      Nothing in this subsection shall require coverage of duplicative  
25 preventive services unless a provider determines the duplicative  
26 services are clinically indicated<sup>1</sup>. As used in this subsection,  
27 "calendar year" means the 12-month period beginning January 1  
28 and ending December 31.] With respect to an annual wellness visit  
29 for a covered member who is over three years of age, a carrier is  
30 required to cover only one wellness visit per plan year or calendar  
31 year, as provided for under the health benefits plan contract, but  
32 may not impose a waiting period for the wellness visit<sup>2</sup>.

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

34

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

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

44       (1) evidence-based items or services that have in effect a rating  
45 of "A" or "B" in the current recommendations of the United States  
46 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 contract which has a network of providers to  
15 provide benefits for items or services described in subsection a. of  
16 this section that are delivered by an out-of-network provider; or

17       (b) preclude a contract 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 contract 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 contract 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 contract 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 contract 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. The provisions of this section shall apply to those medical  
40 service corporation contracts in which the medical service  
41 corporation has reserved the right to change the premium.

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

1       Nothing in this subsection shall require coverage of duplicative  
2       preventive services unless a provider determines the duplicative  
3       services are clinically indicated<sup>1</sup>. 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 health benefits plan contract, but  
9       may not impose a waiting period for the wellness visit<sup>2</sup>.

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

11

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

14       3. a. A health service corporation contract that provides hospital  
15 or 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 contract which has a network of providers to  
37 provide benefits for items or services described in subsection a. of  
38 this section that are delivered by an out-of-network provider; or

39       (b) preclude a contract 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 contract 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 contract 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.

48       c. (1) A contract shall provide coverage for an item or service  
49 described in subsection a. of this section for plan years that begin

1 on or after the date that is one year after the date the  
2 recommendation or guideline is issued.

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

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

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

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

22 Nothing in this subsection shall require coverage of duplicative  
23 preventive services unless a provider determines the duplicative  
24 services are clinically indicated<sup>1</sup>. As used in this subsection,  
25 "calendar year" means the 12-month period beginning January 1  
26 and ending December 31】 With respect to an annual wellness visit  
27 for a covered member who is over three years of age, a carrier is  
28 required to cover only one wellness visit per plan year or calendar  
29 year, as provided for under the health benefits plan contract, but  
30 may not impose a waiting period for the wellness visit<sup>2</sup>.

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

32

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 Nothing in this subsection shall require coverage of duplicative  
44 preventive services unless a provider determines the duplicative  
45 services are clinically indicated<sup>1</sup>. As used in this subsection,  
46 "calendar year" means the 12-month period beginning January 1  
47 and ending December 31】 With respect to an annual wellness visit  
48 for a covered member who is over three years of age, a carrier is

1 required to cover only one wellness visit per plan year or calendar  
2 year, as provided for under the policy, but may not impose a  
3 waiting period for the wellness visit<sup>2</sup>.

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

5

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

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

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

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

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

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

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

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

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

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

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

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

1 year shall provide coverage for that item or service through the last  
2 day of the plan year.

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

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

9 e. ~~2~~A policy shall provide coverage for preventive services  
10 that are recommended on an annual basis at least once per calendar  
11 year, without requiring any waiting period<sup>1</sup>, except the policy may  
12 require a waiting period that is medically necessary to ensure the  
13 safety of the services<sup>1</sup>. ~~1~~This requirement shall not be construed to  
14 add any limitation to the frequency of coverage for preventive  
15 services~~1~~

16 Nothing in this subsection shall require coverage of duplicative  
17 preventive services unless a provider determines the duplicative  
18 services are clinically indicated<sup>1</sup>. As used in this subsection,  
19 "calendar year" means the 12-month period beginning January 1  
20 and ending December 31. With respect to an annual wellness visit  
21 for a covered member who is over three years of age, a carrier is  
22 required to cover only one wellness visit per plan year or calendar  
23 year, as provided for under the policy, but may not impose a  
24 waiting period for the wellness visit<sup>2</sup>.

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

26

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

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

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

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

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

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

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

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

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

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

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

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

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

28          d. This section shall apply to all individual health benefits  
29 plans in which the carrier has reserved the right to change the  
30 premium.

31          e. <sup>2</sup>【A plan shall provide coverage for preventive services that  
32 are recommended on an annual basis at least once per calendar year,  
33 without requiring any waiting period <sup>1</sup>, except the plan may require  
34 a waiting period that is medically necessary to ensure the safety of  
35 the services<sup>1</sup>. <sup>1</sup>【This requirement shall not be construed to add any  
36 limitation to the frequency of coverage for preventive services】

37          Nothing in this subsection shall require coverage of duplicative  
38 preventive services unless a provider determines the duplicative  
39 services are clinically indicated<sup>1</sup>. As used in this subsection,  
40 "calendar year" means the 12-month period beginning January 1  
41 and ending December 31】 With respect to an annual wellness visit  
42 for a covered member who is over three years of age, a carrier is  
43 required to cover only one wellness visit per plan year or calendar  
44 year, as provided for under the health benefits plan contract, but  
45 may not impose a waiting period for the wellness visit<sup>2</sup>.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 d. This section shall apply to all small employer health benefits  
4 plans in which the carrier has reserved the right to change the  
5 premium.

6 e. ~~2[A plan shall provide coverage for preventive services that  
7 are recommended on an annual basis at least once per calendar year,  
8 without requiring any waiting period<sup>1</sup>, except the plan may require  
9 a waiting period that is medically necessary to ensure the safety of  
10 the services<sup>1</sup>.<sup>1</sup>[This requirement shall not be construed to add any  
11 limitation to the frequency of coverage for preventive services.]~~

12 ~~Nothing in this subsection shall require coverage of duplicative  
13 preventive services unless a provider determines the duplicative  
14 services are clinically indicated<sup>1</sup>. As used in this subsection,  
15 "calendar year" means the 12-month period beginning January 1  
16 and ending December 31.] With respect to an annual wellness visit  
17 for a covered member who is over three years of age, a carrier is  
18 required to cover only one wellness visit per plan year or calendar  
19 year, as provided for under the health benefits plan contract, but  
20 may not impose a waiting period for the wellness visit<sup>2</sup>.~~

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

22

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

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

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

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

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

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

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

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

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

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

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

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

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

26       d. The provisions of this section shall apply to those contracts  
27 in which the health maintenance organization has reserved the right  
28 to change the premium.

29       e. <sup>2</sup>【A contract shall provide coverage for preventive services  
30 that are recommended on an annual basis at least once per calendar  
31 year, without requiring any waiting period <sup>1</sup>, except the contract  
32 may require a waiting period that is medically necessary to ensure  
33 the safety of the services<sup>1</sup>. <sup>1</sup>【This requirement shall not be  
34 construed to add any limitation to the frequency of coverage for  
35 preventive services】

36       Nothing in this subsection shall require coverage of duplicative  
37 preventive services unless a provider determines the duplicative  
38 services are clinically indicated<sup>1</sup>. As used in this subsection,  
39 "calendar year" means the 12-month period beginning January 1  
40 and ending December 31】 With respect to an annual wellness visit  
41 for a covered member who is over three years of age, a carrier is  
42 required to cover only one wellness visit per plan year or calendar  
43 year, as provided for under the health benefits plan contract, but  
44 may not impose a waiting period for the wellness visit<sup>2</sup>.

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

46

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

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

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

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

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

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

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

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

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

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

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

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

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

47       d. <sup>2</sup>A contract shall provide coverage for preventive services  
48 that are recommended on an annual basis at least once per calendar  
49 year, without requiring any waiting period <sup>1</sup>, except the contract

1     may require a waiting period that is medically necessary to ensure  
2     the safety of the services<sup>1</sup>. <sup>1</sup>[This requirement shall not be  
3     construed to add any limitation to the frequency of coverage for  
4     preventive services.]

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

14    (cf: P.L.2019, c.360, s.9)

15

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

18    10. a. The School Employees' Health Benefits Commission  
19    shall ensure that every contract purchased by the commission on or  
20    after the effective date of this act that provides hospital or medical  
21    expense benefits shall provide coverage, without requiring any cost  
22    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. <sup>2</sup>A contract 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<sup>1</sup>, except the contract  
19 may require a waiting period that is medically necessary to ensure  
20 the safety of the services<sup>1</sup>. <sup>1</sup>[This requirement shall not be  
21 construed to add any limitation to the frequency of coverage for  
22 preventive services]

23 Nothing in this subsection shall require coverage of duplicative  
24 preventive services unless a provider determines the duplicative  
25 services are clinically indicated<sup>1</sup>. 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 contract is  
29 required to cover only one wellness visit per plan year or calendar  
30 year, as provided for under the contract, but may not impose a  
31 waiting period for the wellness visit<sup>2</sup>.

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

33

34 11. This act shall take effect on <sup>2</sup>the 90th day next following  
35 enactmentJanuary 1, 2027<sup>2</sup> and shall apply to policies or contracts  
36 issued or renewed on or after the effective date.