[Second Reprint]

ASSEMBLY, No. 5785

STATE OF NEW JERSEY

221st LEGISLATURE

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)

AN ACT concerning [2]**[**preventive services**]** annual wellness visits[2] and amending P.L.2019, c.360.

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

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

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

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

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

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

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

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

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

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

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

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:
[1]Assembly AFI committee amendments adopted December 11, 2025.
[2]Senate SBA committee amendments adopted January 8, 2026.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nothing in this subsection shall require coverage of duplicative preventive services unless a provider determines the duplicative services are clinically indicated[1]. As used in this subsection, "calendar year" means the 12-month period beginning January 1 and ending December 31**]** With respect to an annual wellness visit for a covered member who is over three years of age, a carrier is

required to cover only one wellness visit per plan year or calendar year, as provided for under the policy, but may not impose a waiting period for the wellness visit[2].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. [2]**[**A contract shall provide coverage for preventive services that are recommended on an annual basis at least once per calendar year, without requiring any waiting period [1], except the contract

may require a waiting period that is medically necessary to ensure the safety of the services[1]. [1]⟦This requirement shall not be construed to add any limitation to the frequency of coverage for preventive services⟧

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. This act shall take effect on [2]**[**the 90th day next following enactment**]** January 1, 2027[2] and shall apply to policies or contracts issued or renewed on or after the effective date.