

[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)

1 AN ACT concerning ²**[preventive services]** annual wellness visits²
2 and amending P.L.2019, c.360.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

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

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

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

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

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

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

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

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

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

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:

¹Assembly AFI committee amendments adopted December 11, 2025.

²Senate 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. ²[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 ¹, except the contract
20 may require a waiting period that is medically necessary to ensure
21 the safety of the services¹. ¹[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 indicated¹. 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 visit².

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. ²["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 ¹, except the contract
45 may require a waiting period that is medically necessary to ensure
46 the safety of the services¹. ¹["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 indicated¹. As used in this subsection,
4 "calendar year" means the 12-month period beginning January 1
5 and ending December 31.] With respect to an annual wellness visit
6 for a covered member who is over three years of age, a carrier is
7 required to cover only one wellness visit per plan year or calendar
8 year, as provided for under the health benefits plan contract, but
9 may not impose a waiting period for the wellness visit².

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. ²[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 ¹, except the contract
18 may require a waiting period that is medically necessary to ensure
19 the safety of the services¹. ¹[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 indicated¹. 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 visit².

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 ¹, except the policy may
39 require a waiting period that is medically necessary to ensure the
40 safety of the services ¹. 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 ¹. 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 visit².

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 ¹, except the policy may
12 require a waiting period that is medically necessary to ensure the
13 safety of the services ¹. ¹[This requirement shall not be construed to
14 add any limitation to the frequency of coverage for preventive
15 services]

16 Nothing in this subsection shall require coverage of duplicative
17 preventive services unless a provider determines the duplicative
18 services are clinically indicated ¹. 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 ².

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. ²[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 ¹, except the plan may require
34 a waiting period that is medically necessary to ensure the safety of
35 the services ¹. ¹[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 indicated¹. 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 visit².

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 ¹, except the plan may require
9 a waiting period that is medically necessary to ensure the safety of
10 the services¹. ¹[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 indicated¹. 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 visit².

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. ²["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 ¹, except the contract
32 may require a waiting period that is medically necessary to ensure
33 the safety of the services¹. ¹["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 indicated¹. 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 visit².

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. ²A 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 ¹, except the contract

1 may require a waiting period that is medically necessary to ensure
2 the safety of the services¹. ¹【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 indicated¹. 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 visit².

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. ²[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 ¹, except the contract
19 may require a waiting period that is medically necessary to ensure
20 the safety of the services¹. ¹[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 indicated¹. As used in this subsection,
26 "calendar year" means the 12-month period beginning January 1
27 and ending December 31] With respect to an annual wellness visit
28 for a covered member who is over three years of age, a 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 visit².

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

33

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