

SENATE COMMITTEE SUBSTITUTE FOR  
**SENATE, Nos. 4894 and 4726**

**STATE OF NEW JERSEY**  
**221st LEGISLATURE**

ADOPTED DECEMBER 8, 2025

**Sponsored by:**

**Senator JOSEPH F. VITALE**

**District 19 (Middlesex)**

**Senator ANDREW ZWICKER**

**District 16 (Hunterdon, Mercer, Middlesex and Somerset)**

**Assemblywoman CAROL A. MURPHY**

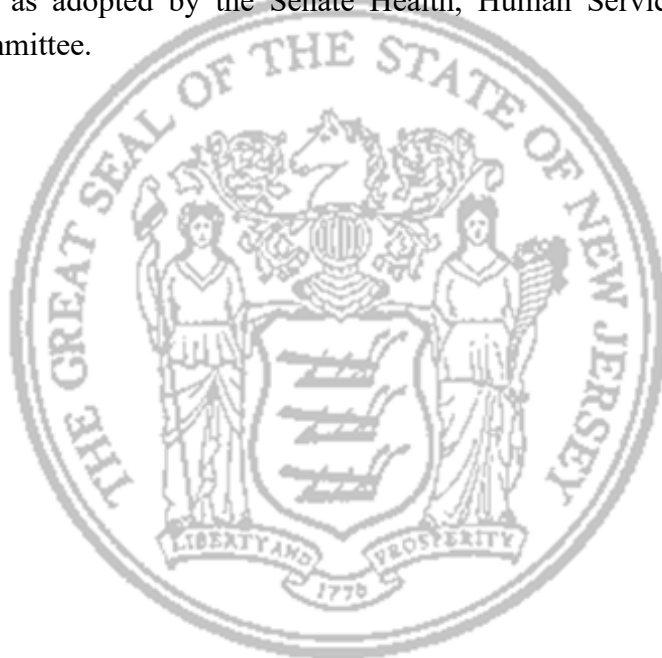
**District 7 (Burlington)**

**SYNOPSIS**

Revises certain references to Advisory Committee on Immunization Practices in statutory and regulatory law; Requires health benefits coverage for certain immunizations recommended by DOH.

**CURRENT VERSION OF TEXT**

Substitute as adopted by the Senate Health, Human Services and Senior Citizens Committee.



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

1 AN ACT concerning insurance and State Medicaid coverage for  
2 immunizations and the Advisory Committee on Immunization  
3 Practices and amending various parts of the statutory law.  
4

5 **BE IT ENACTED** by the Senate and General Assembly of the State  
6 of New Jersey:  
7

8 1. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to  
9 read as follows:

10 2. No hospital service corporation contract providing hospital  
11 or medical expense benefits for groups with greater than 50 persons  
12 shall be delivered, issued, executed, or renewed in this State, or  
13 approved for issuance or renewal in this State by the Commissioner  
14 of Banking and Insurance on or after the effective date of P.L.2005,  
15 c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits  
16 to any named subscriber or other person covered thereunder for  
17 expenses incurred in the following:

18 a. Screening by blood lead measurement for lead poisoning for  
19 children, including confirmatory blood lead testing as specified by  
20 the Department of Health pursuant to section 7 of P.L.1995, c.316  
21 (C.26:2-137.1); and medical evaluation and any necessary medical  
22 follow-up and treatment for lead poisoned children.

23 b. All childhood immunizations as recommended by the  
24 **[Advisory Committee on Immunization Practices of the United**  
25 **States Public Health Service and the]** Department of Health  
26 **[pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)],** which  
27 shall consider the recommendations of the Advisory Committee on  
28 Immunization Practices of the Centers for Disease Control and  
29 Prevention in the federal Department of Health and Human Services  
30 and, as appropriate, the recommendations of the American  
31 Academy of Pediatrics, the American Academy of Family  
32 Physicians, the American College of Obstetricians and  
33 Gynecologists, and the American College of Physicians. A hospital  
34 service corporation shall notify its subscribers, in writing, of any  
35 change in coverage with respect to childhood immunizations and  
36 any related changes in premium. Such notification shall be in a  
37 form and manner to be determined by the Commissioner of Banking  
38 and Insurance.

39 c. Screening for newborn hearing loss by appropriate  
40 electrophysiologic screening measures and periodic monitoring of  
41 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
42 (C.26:2-103.1 et al.). Payment for this screening service shall be  
43 separate and distinct from payment for routine new baby care in the  
44 form of a newborn hearing screening fee as negotiated with the  
45 provider and facility.

**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.**

1 The benefits provided pursuant to this section shall be provided  
2 to the same extent as for any other medical condition under the  
3 contract, except that a deductible shall not be applied for benefits  
4 provided pursuant to this section; however, with respect to a  
5 contract that qualifies as a high deductible health plan for which  
6 qualified medical expenses are paid using a health savings account  
7 established pursuant to section 223 of the federal Internal Revenue  
8 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied  
9 for any benefits provided pursuant to this section which represent  
10 preventive care as permitted by that federal law, and shall not be  
11 applied as provided pursuant to section 6 of P.L.2005, c.248  
12 (C.17:48-6dd). This section shall apply to all hospital service  
13 corporation contracts in which the health service corporation has  
14 reserved the right to change the premium.  
15 (cf: P.L.2012, c.17, s.35)

16

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

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

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

29 (2) immunizations that have in effect a recommendation from  
30 the **【Advisory Committee on Immunization Practices of the Centers**  
31 **for Disease Control and Prevention】** Department of Health, which  
32 shall in making its recommendations consider the recommendations  
33 of the Advisory Committee on Immunization Practices of the  
34 Centers for Disease Control and Prevention in the federal  
35 Department of Health and Human Services and, as appropriate, the  
36 recommendations of the American Academy of Pediatrics, the  
37 American Academy of Family Physicians, the American College of  
38 Obstetricians and Gynecologists, and the American College of  
39 Physicians;

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

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

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

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

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

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

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

32

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

35 3. a. A health service corporation contract 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】** Department of Health, which  
47 shall in making its recommendations consider the recommendations  
48 of the Advisory Committee on Immunization Practices of the

1 Centers for Disease Control and Prevention in the federal  
2 Department of Health and Human Services and, as appropriate, the  
3 recommendations of the American Academy of Pediatrics, the  
4 American Academy of Family Physicians, the American College of  
5 Obstetricians and Gynecologists, and the American College of  
6 Physicians;

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

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

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

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

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

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

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

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

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

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

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

46

47 4. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended  
48 to read as follows:

1 1. No health service corporation contract providing hospital or  
2 medical expense benefits for groups with greater than 50 persons  
3 shall be delivered, issued, executed, or renewed in this State, or  
4 approved for issuance or renewal in this State by the Commissioner  
5 of Banking and Insurance on or after the effective date of P.L.2005,  
6 c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits  
7 to any named subscriber or other person covered thereunder for  
8 expenses incurred in the following:

9 a. Screening by blood lead measurement for lead poisoning for  
10 children, including confirmatory blood lead testing as specified by  
11 the Department of Health pursuant to section 7 of P.L.1995, c.316  
12 (C.26:2-137.1); and medical evaluation and any necessary medical  
13 follow-up and treatment for lead poisoned children.

14 b. All childhood immunizations as recommended by the  
15 **【Advisory Committee on Immunization Practices of the United**  
16 **States Public Health Service and the】** Department of Health  
17 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】**, which  
18 shall consider the recommendations of the Advisory Committee on  
19 Immunization Practices of the Centers for Disease Control and  
20 Prevention in the federal Department of Health and Human Services  
21 and, as appropriate, the recommendations of the American  
22 Academy of Pediatrics, the American Academy of Family  
23 Physicians, the American College of Obstetricians and  
24 Gynecologists, and the American College of Physicians. A health  
25 service corporation shall notify its subscribers, in writing, of any  
26 change in coverage with respect to childhood immunizations and  
27 any related changes in premium. The notification shall be in a form  
28 and manner to be determined by the Commissioner of Banking and  
29 Insurance.

30 c. Screening for newborn hearing loss by appropriate  
31 electrophysiologic screening measures and periodic monitoring of  
32 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
33 (C.26:2-103.1 et al.). Payment for this screening service shall be  
34 separate and distinct from payment for routine new baby care in the  
35 form of a newborn hearing screening fee as negotiated with the  
36 provider and facility.

37 The benefits provided pursuant to this section shall be provided  
38 to the same extent as for any other medical condition under the  
39 contract, except that a deductible shall not be applied for benefits  
40 provided pursuant to this section; however, with respect to a  
41 contract that qualifies as a high deductible health plan for which  
42 qualified medical expenses are paid using a health savings account  
43 established pursuant to section 223 of the federal Internal Revenue  
44 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied  
45 for any benefits provided pursuant to this section which represent  
46 preventive care as permitted by that federal law, and shall not be  
47 applied as provided pursuant to section 3 of P.L.2005, c.248  
48 (C.17:48E-35.28). This section shall apply to all health service

1 corporation contracts in which the health service corporation has  
2 reserved the right to change the premium.

3 (cf: P.L.2012, c.17, s.38)

4

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

7 2. a. A medical service corporation contract that provides  
8 hospital or medical expense benefits and is delivered, issued,  
9 executed or renewed in this State, or approved for issuance or  
10 renewal in this State by the Commissioner of Banking and  
11 Insurance, on or after the effective date of this act, shall provide  
12 coverage, without requiring any cost sharing, for the following  
13 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】** Department of Health, which  
20 shall in making its recommendations consider the recommendations  
21 of the Advisory Committee on Immunization Practices of the  
22 Centers for Disease Control and Prevention in the federal  
23 Department of Health and Human Services and, as appropriate, the  
24 recommendations of the American Academy of Pediatrics, the  
25 American Academy of Family Physicians, the American College of  
26 Obstetricians and Gynecologists, and the American College of  
27 Physicians;

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

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

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

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

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

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

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

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

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

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

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

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

20

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

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

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

32 (2) immunizations that have in effect a recommendation from  
33 the **【Advisory Committee on Immunization Practices of the Centers**  
34 **for Disease Control and Prevention】** Department of Health, which  
35 shall in making its recommendations consider the recommendations  
36 of the Advisory Committee on Immunization Practices of the  
37 Centers for Disease Control and Prevention in the federal  
38 Department of Health and Human Services and, as appropriate, the  
39 recommendations of the American Academy of Pediatrics, the  
40 American Academy of Family Physicians, the American College of  
41 Obstetricians and Gynecologists, and the American College of  
42 Physicians;

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

47 (4) with respect to women, any additional preventive care and  
48 screenings not described in paragraph (1) as provided for in the

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

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

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

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

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

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

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

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

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

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

33

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

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

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

45 (2) immunizations that have in effect a recommendation from  
46 the [Advisory Committee on Immunization Practices of the Centers  
47 for Disease Control and Prevention] Department of Health, which  
48 shall in making its recommendations consider the recommendations

1 of the Advisory Committee on Immunization Practices of the  
2 Centers for Disease Control and Prevention in the federal  
3 Department of Health and Human Services and, as appropriate, the  
4 recommendations of the American Academy of Pediatrics, the  
5 American Academy of Family Physicians, the American College of  
6 Obstetricians and Gynecologists, and the American College of  
7 Physicians;

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

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

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

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

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

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

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

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

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

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

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

46

47 8. Section 3 of P.L.1995, c.316 (C.17B:27-46.11) is amended to  
48 read as follows:

1 3. No group health insurance policy providing hospital or  
2 medical expense benefits for groups with more than 50 persons  
3 shall be delivered, issued, executed, or renewed in this State, or  
4 approved for issuance or renewal in this State by the Commissioner  
5 of Banking and Insurance on or after the effective date of P.L.2005,  
6 c.248 (C.17:48E-35.27 et al.), unless the policy provides benefits to  
7 any named insured or other person covered thereunder for expenses  
8 incurred in the following:

9 a. Screening by blood lead measurement for lead poisoning for  
10 children, including confirmatory blood lead testing as specified by  
11 the Department of Health pursuant to section 7 of P.L.1995, c.316  
12 (C.26:2-137.1); and medical evaluation and any necessary medical  
13 follow-up and treatment for lead poisoned children.

14 b. All childhood immunizations as recommended by the  
15 **【Advisory Committee on Immunization Practices of the United**  
16 **States Public Health Service and the】** Department of Health  
17 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】**, which  
18 shall consider the recommendations of the Advisory Committee on  
19 Immunization Practices of the Centers for Disease Control and  
20 Prevention in the federal Department of Health and Human Services  
21 and, as appropriate, the recommendations of the American  
22 Academy of Pediatrics, the American Academy of Family  
23 Physicians, the American College of Obstetricians and  
24 Gynecologists, and the American College of Physicians. A health  
25 insurer shall notify its policyholders, in writing, of any change in  
26 coverage with respect to childhood immunizations and any related  
27 changes in premium. Such notification shall be in a form and  
28 manner to be determined by the Commissioner of Banking and  
29 Insurance.

30 c. Screening for newborn hearing loss by appropriate  
31 electrophysiologic screening measures and periodic monitoring of  
32 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
33 (C.26:2-103.1 et al.). Payment for this screening service shall be  
34 separate and distinct from payment for routine new baby care in the  
35 form of a newborn hearing screening fee as negotiated with the  
36 provider and facility.

37 The benefits provided pursuant to this section shall be provided  
38 to the same extent as for any other medical condition under the  
39 policy, except that a deductible shall not be applied for benefits  
40 provided pursuant to this section; however, with respect to a policy  
41 that qualifies as a high deductible health plan for which qualified  
42 medical expenses are paid using a health savings account  
43 established pursuant to section 223 of the federal Internal Revenue  
44 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied  
45 for any benefits provided pursuant to this section that represent  
46 preventive care as permitted by that federal law, and shall not be  
47 applied as provided pursuant to section 9 of P.L.2005, c.248  
48 (C.17B:27-46.1dd). This section shall apply to all group health

1 insurance policies in which the health insurer has reserved the right  
2 to change the premium.

3 (cf: P.L.2012, c.17, s.55)

4

5 9. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to  
6 read as follows:

7 6. The commissioner shall approve the policy and contract  
8 forms and benefit levels to be made available by all carriers for the  
9 health benefits plans required to be issued pursuant to section 3 of  
10 P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications  
11 to one or more plans as the board determines are necessary to make  
12 available a "high deductible health plan" or plans consistent with  
13 section 301 of Title III of the "Health Insurance Portability and  
14 Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220),  
15 regarding tax-deductible medical savings accounts, within 60 days  
16 after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The  
17 commissioner shall provide the board with an informational filing  
18 of the policy and contract forms and benefit levels it approves.

19 a. The individual health benefits plans established by the board  
20 may include cost containment measures such as, but not limited to:  
21 utilization review of health care services, including review of  
22 medical necessity of hospital and physician services; case  
23 management benefit alternatives; selective contracting with  
24 hospitals, physicians, and other health care providers; and  
25 reasonable benefit differentials applicable to participating and  
26 nonparticipating providers; and other managed care provisions.

27 b. An individual health benefits plan offered pursuant to  
28 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a  
29 preexisting condition limitation of any period and shall not include  
30 a preexisting condition as a factor in calculating the premium.

31 c. In addition to the standard individual health benefits plans  
32 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the  
33 board may develop up to five rider packages. Premium rates for the  
34 rider packages shall be determined in accordance with section 8 of  
35 P.L.1992, c.161 (C.17B:27A-9).

36 d. After the board's establishment of the individual health  
37 benefits plans required pursuant to section 3 of P.L.1992, c.161  
38 (C.17B:27A-4), and notwithstanding any law to the contrary, a  
39 carrier shall file the policy or contract forms with the commissioner  
40 and certify to the commissioner that the health benefits plans to be  
41 used by the carrier are in substantial compliance with the provisions  
42 in the corresponding approved plans. The certification shall be  
43 signed by the chief executive officer of the carrier. Upon receipt by  
44 the commissioner of the certification, the certified plans may be  
45 used until the commissioner, after notice and hearing, disapproves  
46 their continued use.

47 e. Effective immediately for an individual health benefits plan  
48 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-

1 35.27 et al.) and effective on the first 12-month anniversary date of  
2 an individual health benefits plan in effect on the effective date of  
3 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health  
4 benefits plans required pursuant to section 3 of P.L.1992, c.161  
5 (C.17B:27A-4), including any plan offered by a federally qualified  
6 health maintenance organization, shall contain benefits for expenses  
7 incurred in the following:

8 (1) Screening by blood lead measurement for lead poisoning for  
9 children, including confirmatory blood lead testing as specified by  
10 the Department of Health pursuant to section 7 of P.L.1995, c.316  
11 (C.26:2-137.1); and medical evaluation and any necessary medical  
12 follow-up and treatment for lead poisoned children.

13 (2) All childhood immunizations as recommended by the  
14 **【Advisory Committee on Immunization Practices of the United**  
15 **States Public Health Service and the】** Department of Health  
16 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】, which**  
17 **shall consider the recommendations of the Advisory Committee on**  
18 **Immunization Practices of the Centers for Disease Control and**  
19 **Prevention in the federal Department of Health and Human Services**  
20 **and, as appropriate, the recommendations of the American**  
21 **Academy of Pediatrics, the American Academy of Family**  
22 **Physicians, the American College of Obstetricians and**  
23 **Gynecologists, and the American College of Physicians.** A carrier  
24 shall notify its insureds, in writing, of any change in the health care  
25 services provided with respect to childhood immunizations and any  
26 related changes in premium. Such notification shall be in a form  
27 and manner to be determined by the Commissioner of Banking and  
28 Insurance.

29 (3) Screening for newborn hearing loss by appropriate  
30 electrophysiologic screening measures and periodic monitoring of  
31 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
32 (C.26:2-103.1 et al.). Payment for this screening service shall be  
33 separate and distinct from payment for routine new baby care in the  
34 form of a newborn hearing screening fee as negotiated with the  
35 provider and facility.

36 The benefits provided pursuant to this subsection shall be  
37 provided to the same extent as for any other medical condition  
38 under the health benefits plan, except that a deductible shall not be  
39 applied for benefits provided pursuant to this subsection; however,  
40 with respect to a health benefits plan that qualifies as a high  
41 deductible health plan for which qualified medical expenses are  
42 paid using a health savings account established pursuant to section  
43 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),  
44 a deductible shall not be applied for any benefits provided pursuant  
45 to this subsection that represent preventive care as permitted by that  
46 federal law, and shall not be applied as provided pursuant to section  
47 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall

1 apply to all individual health benefits plans in which the carrier has  
2 reserved the right to change the premium.

3 f. Effective immediately for a health benefits plan issued on or  
4 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
5 effective on the first 12-month anniversary date of a health benefits  
6 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z  
7 et al.), the health benefits plans required pursuant to section 3 of  
8 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses  
9 incurred in the purchase of prescription drugs shall provide benefits  
10 for expenses incurred in the purchase of specialized non-standard  
11 infant formulas, when the covered infant's physician has diagnosed  
12 the infant as having multiple food protein intolerance and has  
13 determined such formula to be medically necessary, and when the  
14 covered infant has not been responsive to trials of standard non-cow  
15 milk-based formulas, including soybean and goat milk. The  
16 coverage may be subject to utilization review, including periodic  
17 review, of the continued medical necessity of the specialized infant  
18 formula.

19 The benefits shall be provided to the same extent as for any other  
20 prescribed items under the health benefits plan.

21 This subsection shall apply to all individual health benefits plans  
22 in which the carrier has reserved the right to change the premium.

23 g. Effective immediately for an individual health benefits plan  
24 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
25 35.27 et al.) and effective on the first 12-month anniversary date of  
26 an individual health benefits plan in effect on the effective date of  
27 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
28 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)  
29 that qualify as high deductible health plans for which qualified  
30 medical expenses are paid using a health savings account  
31 established pursuant to section 223 of the federal Internal Revenue  
32 Code of 1986 (26 U.S.C. s.223), including any plan offered by a  
33 federally qualified health maintenance organization, shall contain  
34 benefits for expenses incurred in connection with any medically  
35 necessary benefits provided in-network which represent preventive  
36 care as permitted by that federal law.

37 The benefits provided pursuant to this subsection shall be  
38 provided to the same extent as for any other medical condition  
39 under the health benefits plan, except that a deductible shall not be  
40 applied for benefits provided pursuant to this subsection. This  
41 subsection shall apply to all individual health benefits plans in  
42 which the carrier has reserved the right to change the premium.

43 (cf: P.L.2019, c.353, s.4)

44

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

47 6. a. An individual health benefits plan that provides hospital  
48 or medical expense benefits and is delivered, issued, executed or

1 renewed in this State, or approved for issuance or renewal in this  
2 State by the Commissioner of Banking and Insurance, on or after  
3 the effective date of this act, shall provide coverage, without  
4 requiring any cost sharing, for the following preventive services:

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

8 (2) immunizations that have in effect a recommendation from  
9 the [Advisory Committee on Immunization Practices of the Centers  
10 for Disease Control and Prevention] Department of Health, which  
11 shall in making its recommendations consider the recommendations  
12 of the Advisory Committee on Immunization Practices of the  
13 Centers for Disease Control and Prevention in the federal  
14 Department of Health and Human Services and, as appropriate, the  
15 recommendations of the American Academy of Pediatrics, the  
16 American Academy of Family Physicians, the American College of  
17 Obstetricians and Gynecologists, and the American College of  
18 Physicians;

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

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

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

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

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

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

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

45 (2) (a) Except as provided in subparagraph (b) of this paragraph,  
46 a plan that is required to provide coverage for an item or service  
47 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 all individual health benefits  
8 plans in which the carrier has reserved the right to change the  
9 premium.

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

11

12 11. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to  
13 read as follows:

14 3. a. Except as provided in subsection f. of this section, every  
15 small employer carrier shall, as a condition of transacting business  
16 in this State, offer to every small employer at least three of the  
17 health benefit plans established by the board, as provided in this  
18 section. The board shall establish a standard policy form for each  
19 of the plans, which except as otherwise provided in subsection j. of  
20 this section, shall be the only plans offered to small groups on or  
21 after January 1, 1994. One policy form shall contain the benefits  
22 provided for in sections 55, 57, and 59 of P.L.1991, c. 187  
23 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of  
24 indemnity carriers, one policy form shall be established which  
25 contains benefits and cost sharing levels which are equivalent to the  
26 health benefits plans of health maintenance organizations pursuant  
27 to the "Health Maintenance Organization Act of 1973," Pub.L.93-  
28 222 (42 U.S.C. s.300e et seq.). The remaining policy forms shall  
29 contain basic hospital and medical-surgical benefits, including, but  
30 not limited to:

- 31 (1) Basic inpatient and outpatient hospital care;  
32 (2) Basic and extended medical-surgical benefits;  
33 (3) Diagnostic tests, including X-rays;  
34 (4) Maternity benefits, including prenatal and postnatal care; and  
35 (5) Preventive medicine, including periodic physical  
36 examinations and inoculations.

37 At least three of the forms shall provide for major medical  
38 benefits in varying lifetime aggregates, one of which shall provide  
39 at least \$1,000,000 in lifetime aggregate benefits. The policy forms  
40 provided pursuant to this section shall contain benefits representing  
41 progressively greater actuarial values.

42 Notwithstanding the provisions of this subsection to the contrary,  
43 the board also may establish additional policy forms by which a  
44 small employer carrier, other than a health maintenance  
45 organization, may provide indemnity benefits or health maintenance  
46 organization enrollees by direct contract with the enrollees' small  
47 employer through a dual arrangement with the health maintenance  
48 organization. The dual arrangement shall be filed with the

1 commissioner for approval. The additional policy forms shall be  
2 consistent with the general requirements of P.L.1992, c.162  
3 (C.17B:27A-17 et seq.).

4 b. Initially, a carrier shall offer a plan within 90 days of the  
5 approval of such plan by the commissioner. Thereafter, the plans  
6 shall be available to all small employers on a continuing basis.  
7 Every small employer which elects to be covered under any health  
8 benefits plan who pays the premium therefor and who satisfies the  
9 participation requirements of the plan shall be issued a policy or  
10 contract by the carrier.

11 c. The carrier may establish a premium payment plan which  
12 provides installment payments and which may contain reasonable  
13 provisions to ensure payment security, provided that provisions to  
14 ensure payment security are uniformly applied.

15 d. In addition to the standard policies described in subsection a.  
16 of this section, the board may develop up to five rider packages.  
17 Any such package which a carrier chooses to offer shall be issued to  
18 a small employer who pays the premium therefor, and shall be  
19 subject to rating methodology set forth in section 9 of P.L.1992,  
20 c.162 (C.17B:27A-25).

21 e. (Deleted by amendment, P.L.2008, c.38).

22 f. Notwithstanding the provisions of this section to the  
23 contrary, a health maintenance organization which is a qualified  
24 health maintenance organization pursuant to the "Health  
25 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.  
26 s.300e et seq.) shall be permitted to offer health benefits plans  
27 formulated by the board and approved by the commissioner which  
28 are in accordance with the provisions of that law in lieu of the five  
29 plans required pursuant to this section.

30 Notwithstanding the provisions of this section to the contrary, a  
31 health maintenance organization which is approved pursuant to  
32 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health  
33 benefits plans formulated by the board and approved by the  
34 commissioner which are in accordance with the provisions of that  
35 law in lieu of the plans required pursuant to this section, except that  
36 the plans shall provide the same level of benefits as required for a  
37 federally qualified health maintenance organization, including any  
38 requirements concerning copayments by enrollees.

39 g. A carrier shall not be required to own or control a health  
40 maintenance organization or otherwise affiliate with a health  
41 maintenance organization in order to comply with the provisions of  
42 this section, but the carrier shall be required to offer at least three of  
43 the benefits plans which are formulated by the board and approved  
44 by the commissioner, including one plan which contains benefits  
45 and cost sharing levels that are equivalent to those required for  
46 health maintenance organizations.

47 h. Notwithstanding the provisions of subsection a. of this  
48 section to the contrary, the board may modify the benefits provided

1 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,  
2 17B:26B-2 and 26:2J-4.3).

3 i. (1) In addition to the rider packages provided for in subsection  
4 d. of this section, every carrier may offer, in connection with the  
5 health benefits plans required to be offered by this section, any  
6 number of riders which may revise the coverage offered by the  
7 plans in any way, provided, however, that any form of such rider or  
8 amendment thereof which decreases benefits or decreases the  
9 actuarial value of a plan shall be filed for informational purposes  
10 with the board and for approval by the commissioner before such  
11 rider may be sold. Any rider or amendment thereof which adds  
12 benefits or increases the actuarial value of a plan shall be filed with  
13 the board for informational purposes before such rider may be sold.  
14 The added premium or reduction in premium for each rider, as  
15 applicable, shall be listed separately from the premium for the  
16 standard plan.

17 The commissioner shall disapprove any rider filed pursuant to  
18 this subsection that is unjust, unfair, inequitable, unreasonably  
19 discriminatory, misleading, contrary to law or the public policy of  
20 this State. The commissioner shall not approve any rider which  
21 reduces benefits below those required by sections 55, 57 and 59 of  
22 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and  
23 required to be sold pursuant to this section. The commissioner's  
24 determination shall be in writing and shall be appealable.

25 (2) The benefit riders provided for in paragraph (1) of this  
26 subsection shall be subject to the provisions of section 2, subsection  
27 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162  
28 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-  
29 24, 17B:27A-25, and 17B:27A-27).

30 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
31 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
32 by or through a carrier, association, or multiple employer  
33 arrangement prior to January 1, 1994 or, if the requirements of  
34 subparagraph (c) of paragraph (6) of this subsection are met, issued  
35 by or through an out-of-State trust prior to January 1, 1994, at the  
36 option of a small employer policy or contract holder, may be  
37 renewed or continued after February 28, 1994, or in the case of such  
38 a health benefits plan whose anniversary date occurred between  
39 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-  
40 19.1 et al.), may be reinstated within 60 days of that anniversary  
41 date and renewed or continued if, beginning on the first 12-month  
42 anniversary date occurring on or after the sixtieth day after the  
43 board adopts regulations concerning the implementation of the  
44 rating factors permitted by section 9 of P.L.1992, c.162  
45 (C.17B:27A-25) and, regardless of the situs of delivery of the health  
46 benefits plan, the health benefits plan renewed, continued or  
47 reinstated pursuant to this subsection complies with the provisions  
48 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and

1 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,  
2 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and  
3 section 7 of P.L.1995, c.340 (C17B:27A-19.3).

4 Nothing in this subsection shall be construed to require an  
5 association, multiple employer arrangement or out-of-State trust to  
6 provide health benefits coverage to small employers that are not  
7 contemplated by the organizational documents, bylaws, or other  
8 regulations governing the purpose and operation of the association,  
9 multiple employer arrangement or out-of-State trust.  
10 Notwithstanding the foregoing provision to the contrary, an  
11 association, multiple employer arrangement or out-of-State trust  
12 that offers health benefits coverage to its members' employees and  
13 dependents:

14 (a) shall offer coverage to all eligible employees and their  
15 dependents within the membership of the association, multiple  
16 employer arrangement or out-of-State trust;

17 (b) shall not use actual or expected health status in determining  
18 its membership; and

19 (c) shall make available to its small employer members at least  
20 one of the standard benefits plans, as determined by the  
21 commissioner, in addition to any health benefits plan permitted to  
22 be renewed or continued pursuant to this subsection.

23 (2) Notwithstanding the provisions of this subsection to the  
24 contrary, a carrier or out-of-State trust which writes the health  
25 benefits plans required pursuant to subsection a. of this section shall  
26 be required to offer those plans to any small employer, association  
27 or multiple employer arrangement.

28 (3) (a) A carrier, association, multiple employer arrangement, or  
29 out-of-State trust may withdraw a health benefits plan marketed to  
30 small employers that was in effect on December 31, 1993 with the  
31 approval of the commissioner. The commissioner shall approve a  
32 request to withdraw a plan, consistent with regulations adopted by  
33 the commissioner, only on the grounds that retention of the plan  
34 would cause an unreasonable financial burden to the issuing carrier,  
35 taking into account the rating provisions of section 9 of P.L.1992,  
36 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340  
37 (C.17B:27A-19.3).

38 (b) A carrier which has renewed, continued or reinstated a health  
39 benefits plan pursuant to this subsection that has not been newly  
40 issued to a new small employer group since January 1, 1994, may,  
41 upon approval of the commissioner, continue to establish its rates  
42 for that plan based on the loss experience of that plan if the carrier  
43 does not issue that health benefits plan to any new small employer  
44 groups.

45 (4) (Deleted by amendment, P.L.1995, c.340).

46 (5) A health benefits plan that otherwise conforms to the  
47 requirements of this subsection shall be deemed to be in compliance

1 with this subsection, notwithstanding any change in the plan's  
2 deductible or copayment.

3 (6) (a) Except as otherwise provided in subparagraphs (b) and (c)  
4 of this paragraph, a health benefits plan renewed, continued or  
5 reinstated pursuant to this subsection shall be filed with the  
6 commissioner for informational purposes within 30 days after its  
7 renewal date. No later than 60 days after the board adopts  
8 regulations concerning the implementation of the rating factors  
9 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing  
10 shall be amended to show any modifications in the plan that are  
11 necessary to comply with the provisions of this subsection. The  
12 commissioner shall monitor compliance of any such plan with the  
13 requirements of this subsection, except that the board shall enforce  
14 the loss ratio requirements.

15 (b) A health benefits plan filed with the commissioner pursuant  
16 to subparagraph (a) of this paragraph may be amended as to its  
17 benefit structure if the amendment does not reduce the actuarial  
18 value and benefits coverage of the health benefits plan below that of  
19 the lowest standard health benefits plan established by the board  
20 pursuant to subsection a. of this section. The amendment shall be  
21 filed with the commissioner for approval pursuant to the terms of  
22 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,  
23 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as  
24 applicable, and shall comply with the provisions of sections 2 and 9  
25 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7  
26 of P.L.1995, c.340 (C.17B:27A-19.3).

27 (c) A health benefits plan issued by a carrier through an out-of-  
28 State trust shall be permitted to be renewed or continued pursuant to  
29 paragraph (1) of this subsection upon approval by the commissioner  
30 and only if the benefits offered under the plan are at least equal to  
31 the actuarial value and benefits coverage of the lowest standard  
32 health benefits plan established by the board pursuant to subsection  
33 a. of this section. For the purposes of meeting the requirements of  
34 this subparagraph, carriers shall be required to file with the  
35 commissioner the health benefits plans issued through an out-of-  
36 State trust no later than 180 days after the date of enactment of  
37 P.L.1995, c.340. A health benefits plan issued by a carrier through  
38 an out-of-State trust that is not filed with the commissioner pursuant  
39 to this subparagraph, shall not be permitted to be continued or  
40 renewed after the 180-day period.

41 (7) Notwithstanding the provisions of P.L.1992, c.162  
42 (C.17B:27A-17 et seq.) to the contrary, an association, multiple  
43 employer arrangement or out-of-State trust may offer a health  
44 benefits plan authorized to be renewed, continued or reinstated  
45 pursuant to this subsection to small employer groups that are  
46 otherwise eligible pursuant to paragraph (1) of subsection j. of this  
47 section during the period for which such health benefits plan is  
48 otherwise authorized to be renewed, continued or reinstated.

1 (8) Notwithstanding the provisions of P.L.1992, c.162  
2 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,  
3 multiple employer arrangement or out-of-State trust may offer  
4 coverage under a health benefits plan authorized to be renewed,  
5 continued or reinstated pursuant to this subsection to new  
6 employees of small employer groups covered by the health benefits  
7 plan in accordance with the provisions of paragraph (1) of this  
8 subsection.

9 (9) Notwithstanding the provisions of P.L.1992, c.162  
10 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to  
11 the contrary, any individual, who is eligible for small employer  
12 coverage under a policy issued, renewed, continued or reinstated  
13 pursuant to this subsection, but who would be subject to a  
14 preexisting condition exclusion under the small employer health  
15 benefits plan, or who is a member of a small employer group who  
16 has been denied coverage under the small employer group health  
17 benefits plan for health reasons, may elect to purchase or continue  
18 coverage under an individual health benefits plan until such time as  
19 the group health benefits plan covering the small employer group of  
20 which the individual is a member complies with the provisions of  
21 P.L.1992, c.162 (C.17B:27A-17 et seq.).

22 (10) In a case in which an association made available a health  
23 benefits plan on or before March 1, 1994 and subsequently changed  
24 the issuing carrier between March 1, 1994 and the effective date of  
25 P.L.1995, c.340, the new issuing carrier shall be deemed to have  
26 been eligible to continue and renew the plan pursuant to paragraph  
27 (1) of this subsection.

28 (11) In a case in which an association, multiple employer  
29 arrangement or out-of-State trust made available a health benefits  
30 plan on or before March 1, 1994 and subsequently changes the  
31 issuing carrier for that plan after the effective date of P.L.1995,  
32 c.340, the new issuing carrier shall file the health benefits plan with  
33 the commissioner for approval in order to be deemed eligible to  
34 continue and renew that plan pursuant to paragraph (1) of this  
35 subsection.

36 (12) In a case in which a small employer purchased a health  
37 benefits plan directly from a carrier on or before March 1, 1994 and  
38 subsequently changes the issuing carrier for that plan after the  
39 effective date of P.L.1995, c.340, the new issuing carrier shall file  
40 the health benefits plan with the commissioner for approval in order  
41 to be deemed eligible to continue and renew that plan pursuant to  
42 paragraph (1) of this subsection.

43 Notwithstanding the provisions of subparagraph (b) of paragraph  
44 (6) of this subsection to the contrary, a small employer who changes  
45 its health benefits plan's issuing carrier pursuant to the provisions of  
46 this paragraph, shall not, upon changing carriers, modify the benefit  
47 structure of that health benefits plan within six months of the date  
48 the issuing carrier was changed.

1 k. Effective immediately for a health benefits plan issued on or  
2 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)  
3 and effective on the first 12-month anniversary date of a health  
4 benefits plan in effect on the effective date of P.L.2005, c.248  
5 (C.17:48E-35.27 et al.), the health benefits plans required pursuant  
6 to this section, including any plans offered by a State approved or  
7 federally qualified health maintenance organization, shall contain  
8 benefits for expenses incurred in the following:

9 (1) Screening by blood lead measurement for lead poisoning for  
10 children, including confirmatory blood lead testing as specified by  
11 the Department of Health pursuant to section 7 of P.L.1995, c.316  
12 (C.26:2-137.1); and medical evaluation and any necessary medical  
13 follow-up and treatment for lead poisoned children.

14 (2) All childhood immunizations as recommended by the  
15 **【Advisory Committee on Immunization Practices of the United**  
16 **States Public Health Service and the】** Department of Health  
17 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】, which**  
18 **shall consider the recommendations of the Advisory Committee on**  
19 **Immunization Practices of the Centers for Disease Control and**  
20 **Prevention in the federal Department of Health and Human Services**  
21 **and, as appropriate, the recommendations of the American**  
22 **Academy of Pediatrics, the American Academy of Family**  
23 **Physicians, the American College of Obstetricians and**  
24 **Gynecologists, and the American College of Physicians.** A carrier  
25 shall notify its insureds, in writing, of any change in the health care  
26 services provided with respect to childhood immunizations and any  
27 related changes in premium. Such notification shall be in a form  
28 and manner to be determined by the Commissioner of Banking and  
29 Insurance.

30 (3) Screening for newborn hearing loss by appropriate  
31 electrophysiologic screening measures and periodic monitoring of  
32 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
33 (C.26:2-103.1 et al.). Payment for this screening service shall be  
34 separate and distinct from payment for routine new baby care in the  
35 form of a newborn hearing screening fee as negotiated with the  
36 provider and facility.

37 The benefits provided pursuant to this subsection shall be  
38 provided to the same extent as for any other medical condition  
39 under the health benefits plan, except that a deductible shall not be  
40 applied for benefits provided pursuant to this subsection; however,  
41 with respect to a small employer health benefits plan that qualifies  
42 as a high deductible health plan for which qualified medical  
43 expenses are paid using a health savings account established  
44 pursuant to section 223 of the federal Internal Revenue Code of  
45 1986 (26 U.S.C. s.223), a deductible shall not be applied for any  
46 benefits that represent preventive care as permitted by that federal  
47 law, and shall not be applied as provided pursuant to section 16 of  
48 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to

1 all small employer health benefits plans in which the carrier has  
2 reserved the right to change the premium.

3 1. The board shall consider including benefits for speech-  
4 language pathology and audiology services, as rendered by speech-  
5 language pathologists and audiologists within the scope of their  
6 practices, in at least one of the standard policies and in at least one  
7 of the five riders to be developed under this section.

8 m. Effective immediately for a health benefits plan issued on or  
9 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
10 effective on the first 12-month anniversary date of a health benefits  
11 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z  
12 et al.), the health benefits plans required pursuant to this section  
13 that provide benefits for expenses incurred in the purchase of  
14 prescription drugs shall provide benefits for expenses incurred in  
15 the purchase of specialized non-standard infant formulas, when the  
16 covered infant's physician has diagnosed the infant as having  
17 multiple food protein intolerance and has determined such formula  
18 to be medically necessary, and when the covered infant has not been  
19 responsive to trials of standard non-cow milk-based formulas,  
20 including soybean and goat milk. The coverage may be subject to  
21 utilization review, including periodic review, of the continued  
22 medical necessity of the specialized infant formula.

23 The benefits shall be provided to the same extent as for any other  
24 prescribed items under the health benefits plan.

25 This subsection shall apply to all small employer health benefits  
26 plans in which the carrier has reserved the right to change the  
27 premium.

28 n. Effective immediately for a health benefits plan issued on or  
29 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)  
30 and effective on the first 12-month anniversary date of a small  
31 employer health benefits plan in effect on the effective date of  
32 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
33 required pursuant to this section that qualify as high deductible  
34 health plans for which qualified medical expenses are paid using a  
35 health savings account established pursuant to section 223 of the  
36 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including  
37 any plans offered by a State approved or federally qualified health  
38 maintenance organization, shall contain benefits for expenses  
39 incurred in connection with any medically necessary benefits  
40 provided in-network that represent preventive care as permitted by  
41 that federal law.

42 The benefits provided pursuant to this subsection shall be  
43 provided to the same extent as for any other medical condition  
44 under the health benefits plan, except that no deductible shall be  
45 applied for benefits provided pursuant to this subsection. This  
46 subsection shall apply to all small employer health benefits plans in  
47 which the carrier has reserved the right to change the premium.

48 (cf: P.L.2023, c.194, s.3)

1       12. 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】** Department of Health, which  
16 shall in making its recommendations consider the recommendations  
17 of the Advisory Committee on Immunization Practices of the  
18 Centers for Disease Control and Prevention in the federal  
19 Department of Health and Human Services and, as appropriate, the  
20 recommendations of the American Academy of Pediatrics, the  
21 American Academy of Family Physicians, the American College of  
22 Obstetricians and Gynecologists, and the American College of  
23 Physicians;

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

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

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

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

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

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

46       c. (1) A plan shall provide coverage for an item or service  
47 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 plan 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. This section shall apply to all small employer health benefits  
13 plans in which the carrier has reserved the right to change the  
14 premium.

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

16

17 13. Section 2 of P.L.2003, c.284 (C.18A:62-15.1) is amended to  
18 read as follows:

19 2. a. Beginning in September 2004, a new student enrolling in a  
20 public or private institution of higher education in this State shall  
21 have received immunization for meningococcal disease as  
22 recommended by the **【Advisory Committee on Immunization**  
23 **Practices of the Centers for Disease Control and Prevention】**  
24 Department of Health, which shall consider the recommendations of  
25 the Advisory Committee on Immunization Practices of the Centers  
26 for Disease Control and Prevention in the federal Department of  
27 Health and Human Services and, as appropriate, the  
28 recommendations of the American Academy of Pediatrics, the  
29 American Academy of Family Physicians, the American College of  
30 Obstetricians and Gynecologists, and the American College of  
31 Physicians, as a condition of attendance at that institution, except as  
32 provided in section 3 of P.L.2003, c.284 (C.18A:62-15.2).

33 b. A student shall present evidence of the vaccination required  
34 pursuant to subsection a. of this section to the institution in a  
35 manner prescribed by the institution.

36 c. The Department of Health shall require each public or  
37 private institution of higher education in this State to offer the  
38 immunization required pursuant to subsection a. of this section to  
39 its students through the institution's student health services program  
40 or through a contractual agreement with a community health care  
41 provider.

42 d. The Commissioner of Health shall adopt rules and  
43 regulations pursuant to the "Administrative Procedure Act,"  
44 P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of  
45 subsections a., b. and c. of this section and section 3 of P.L.2003,  
46 c.284 (C.18A:62-15.2).

47 (cf: P.L.2019, c.332, s.1)

1 14. Section 7 of P.L.1995, c.316 (C.26:2-137.1) is amended to  
2 read as follows:

3 7. The Department of Health shall specify by regulation,  
4 pursuant to the "Administrative Procedure Act," P.L.1968, c.410  
5 (C.52:14B-1 et seq.):

6 a. The lead screening requirements provided for under  
7 P.L.1995, c.316 (C.17:48E-35.10 et al.), including the age of the  
8 child when initial screening should be conducted, the time intervals  
9 between screening, when follow-up testing is required, the methods  
10 that shall be used to conduct the lead screening, and, in accordance  
11 with the latest recommendations of the federal Centers for Disease  
12 Control and Prevention and the provisions of P.L.1995, c.328  
13 (C.26:2-137.2 et seq.), the level of lead in the bloodstream that shall  
14 necessitate the undertaking of responsive action; and

15 b. The childhood immunizations recommended by the  
16 **【Advisory Committee on Immunization Practices of the United**  
17 **States Public Health Service and the】** Department of Health, which  
18 shall consider the recommendations of the Advisory Committee on  
19 Immunization Practices of the Centers for Disease Control and  
20 Prevention in the federal Department of Health and Human Services  
21 and, as appropriate, the recommendations of the American  
22 Academy of Pediatrics, the American Academy of Family  
23 Physicians, the American College of Obstetricians and  
24 Gynecologists, and the American College of Physicians.  
25 (cf: P.L.2017, c.7, s.2)

26

27 15. Section 1 of P.L.2019, c.330 (C.26:2H-18.79) is amended to  
28 read as follows:

29 1. a. As used in this act:

30 "Commissioner" means the Commissioner of Health.

31 "Health care facility" means a general or special hospital,  
32 nursing home, or home health care agency licensed pursuant to  
33 P.L.1971, c.136 (C.26:2H-1 et seq.).

34 b. Commencing with the onset of the first influenza season  
35 next following the effective date of this act, each health care facility  
36 shall establish and implement an annual influenza vaccination  
37 program in accordance with the current recommendations of the  
38 **【Advisory Committee on Immunization Practices of the federal**  
39 **Centers for Disease Control and Prevention】** Department of Health,  
40 which shall in making its recommendations consider the  
41 recommendations of the Advisory Committee on Immunization  
42 Practices of the Centers for Disease Control and Prevention in the  
43 federal Department of Health and Human Services and, as  
44 appropriate, the recommendations of the American Academy of  
45 Pediatrics, the American Academy of Family Physicians, the  
46 American College of Obstetricians and Gynecologists, and the  
47 American College of Physicians, and any rules and regulations  
48 adopted by the commissioner pursuant to this act.

- 1 c. For the purposes of its annual influenza vaccination  
2 program, each health care facility shall:
- 3 (1) annually provide an on-site or off-site influenza vaccination  
4 to each of its employees;
- 5 (2) require that each employee at the facility receive an  
6 influenza vaccination annually, no later than December 31 of the  
7 current influenza season as determined by the federal Centers for  
8 Disease Control and Prevention, which vaccination shall be  
9 provided by the health care facility, except that an employee may,  
10 in lieu of receiving the influenza vaccination at the facility, present  
11 acceptable proof, comprising:
- 12 (a) an attestation from the employee, which shall be submitted  
13 in a form and manner designated by the facility, of a current  
14 influenza vaccination if the employee receives the vaccination from  
15 another vaccination source, which attestation shall include the lot  
16 number of the vaccination the employee received or;
- 17 (b) a medical exemption, which shall be submitted using a form  
18 designated by the Department of Health, stating that the influenza  
19 vaccination for that employee is medically contraindicated, as  
20 enumerated by the **【Advisory Committee on Immunization**  
21 **Practices of the federal Centers for Disease Control and Prevention】**  
22 Department of Health. An attestation of a medical exemption shall  
23 be subject to approval by the facility following a review by the  
24 facility to confirm the medical exemption is consistent with  
25 standards enumerated by the **【Advisory Committee on**  
26 **Immunization Practices】** Department of Health;
- 27 (3) maintain a record or attestation, as applicable, of influenza  
28 vaccinations and medical exemptions for each employee and report  
29 to the Department of Health, in a manner and according to a  
30 schedule prescribed by the commissioner, the vaccination  
31 percentage rate of its workforce in receiving influenza vaccinations  
32 as part of the facility's annual vaccination program or by other  
33 means as attested to by the workforce, as applicable. The report  
34 may also include other information that the facility deems relevant  
35 to its vaccination percentage rate, including, but not limited to, the  
36 number of employees who received medical exemptions;
- 37 (4) provide an educational component to its program that is  
38 designed to inform employees about: influenza vaccination; non-  
39 vaccine influenza control measures; and the symptoms,  
40 transmission, and potential impact of influenza;
- 41 (5) annually conduct an evaluation of the program with the goal  
42 of improving the rate of vaccination among its employees; and
- 43 (6) require any employee who does not receive an influenza  
44 vaccination to wear a surgical or procedural mask when in direct  
45 contact with patients and in common areas, as specified in facility  
46 policy, or to be removed from direct patient care responsibilities  
47 during influenza season.

1 d. A health care facility may suspend its annual influenza  
2 vaccination program pursuant to this act in the event of a shortage  
3 of influenza vaccine as determined by the commissioner.

4 e. (1) The commissioner may assess such penalties and take  
5 other actions against a health care facility, as provided in P.L.1971,  
6 c.136 (C.26:2H-1 et seq.), or any rules and regulations adopted  
7 pursuant thereto, for any determination by the commissioner of  
8 noncompliance by a health care facility or any of its employees with  
9 the provisions of this act.

10 (2) The commissioner shall seek to minimize any record-  
11 keeping burden imposed on a health care facility pursuant to this act  
12 and shall take such actions as are necessary to ensure the  
13 confidentiality of any data furnished to the department pursuant to  
14 this act that may contain information identifying an individual  
15 employee.

16 (3) The commissioner shall make available to the public  
17 aggregate data reported by a facility pursuant to paragraph (3) of  
18 subsection c. of this section.

19 f. A health care facility shall not discharge or reduce the pay of  
20 an employee who receives a medical exemption from the annual  
21 influenza vaccination requirement.

22 g. Nothing in this section shall be construed to prohibit a health  
23 care facility from adopting additional policies and procedures with  
24 regard to the annual influenza vaccine that are not inconsistent with  
25 the requirements of this section.

26 (cf: P.L.2019, c.330, s.1)

27  
28 16. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to  
29 read as follows:

30 4. A certificate of authority to establish and operate a health  
31 maintenance organization in this State shall not be issued or  
32 continued by the Commissioner of Banking and Insurance on or  
33 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)  
34 unless the health maintenance organization offers health care  
35 services to any enrollee which include:

36 a. Screening by blood lead measurement for lead poisoning for  
37 children, including confirmatory blood lead testing as specified by  
38 the Department of Health pursuant to section 7 of P.L.1995, c.316  
39 (C.26:2-137.1); and medical evaluation and any necessary medical  
40 follow-up and treatment for lead poisoned children.

41 b. All childhood immunizations as recommended by the  
42 **【Advisory Committee on Immunization Practices of the United**  
43 **States Public Health Service and the】** Department of Health  
44 **【pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1)】, which**  
45 **shall consider the recommendations of the Advisory Committee on**  
46 **Immunization Practices of the Centers for Disease Control and**  
47 **Prevention in the federal Department of Health and Human Services**  
48 **and, as appropriate, the recommendations of the American**

1 Academy of Pediatrics, the American Academy of Family  
2 Physicians, the American College of Obstetricians and  
3 Gynecologists, and the American College of Physicians. A health  
4 maintenance organization shall notify its enrollees, in writing, of  
5 any change in the health care services provided with respect to  
6 childhood immunizations and any related changes in premium. The  
7 notification shall be in a form and manner to be determined by the  
8 Commissioner of Banking and Insurance.

9 c. Screening for newborn hearing loss by appropriate  
10 electrophysiologic screening measures and periodic monitoring of  
11 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
12 (C.26:2-103.1 et al.). Payment for this screening service shall be  
13 separate and distinct from payment for routine new baby care in the  
14 form of a newborn hearing screening fee as negotiated with the  
15 provider and facility.

16 The health care services provided pursuant to this section shall  
17 be provided to the same extent as for any other medical condition  
18 under the contract, except that a deductible shall not be applied for  
19 services provided pursuant to this section; however, with respect to  
20 a contract that qualifies as a high deductible health plan for which  
21 qualified medical expenses are paid using a health savings account  
22 established pursuant to section 223 of the federal Internal Revenue  
23 Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied  
24 for any services provided pursuant to this section that represent  
25 preventive care as permitted by that federal law, and shall not be  
26 applied as provided pursuant to section 12 of P.L.2005, c.248  
27 (C.26:2J-4.29). This section shall apply to all contracts under  
28 which the health maintenance organization has reserved the right to  
29 change the schedule of charges for enrollee coverage.

30 (cf: P.L.2012, c.17, s.265)

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

34 8. a. A health maintenance organization contract that provides  
35 hospital or medical expense benefits and is delivered, issued,  
36 executed or renewed in this State, or approved for issuance or  
37 renewal in this State by the Commissioner of Banking and  
38 Insurance, on or after the effective date of this act, shall provide  
39 coverage, without requiring any cost sharing, for the following  
40 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】** Department of Health, which  
47 shall in making its recommendations consider the recommendations  
48 of the Advisory Committee on Immunization Practices of the

1 Centers for Disease Control and Prevention in the federal  
2 Department of Health and Human Services and, as appropriate, the  
3 recommendations of the American Academy of Pediatrics, the  
4 American Academy of Family Physicians, the American College of  
5 Obstetricians and Gynecologists, and the American College of  
6 Physicians;

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

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

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

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

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

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

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

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

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

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

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

46

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

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

6       (1) Inpatient hospital services

7       (2) Outpatient hospital services;

8       (3) Other laboratory and X-ray services;

9       (4) (a) Skilled nursing or intermediate care facility services;

10       (b) Early and periodic screening and diagnosis of individuals  
11 who are eligible under the program and are under age 21, to  
12 ascertain their physical or mental health status and the health care,  
13 treatment, and other measures to correct or ameliorate defects and  
14 chronic conditions discovered thereby, as may be provided in  
15 regulation of the Secretary of the federal Department of Health and  
16 Human Services and approved by the commissioner;

17       (5) Physician's services furnished in the office, the patient's  
18 home, a hospital, a skilled nursing, or intermediate care facility or  
19 elsewhere.

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

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

31       (1) Medical care not included in subsection a.(5) above, or any  
32 other type of remedial care recognized under State law, furnished  
33 by licensed practitioners within the scope of their practice, as  
34 defined by State law;

35       (2) Home health care services;

36       (3) Clinic services;

37       (4) Dental services;

38       (5) Physical therapy and related services;

39       (6) Prescribed drugs, dentures, and prosthetic devices; and  
40 eyeglasses prescribed by a physician skilled in diseases of the eye  
41 or by an optometrist, whichever the individual may select;

42       (7) Optometric services;

43       (8) Podiatric services;

44       (9) Chiropractic services;

45       (10) Psychological services;

46       (11) Inpatient psychiatric hospital services for individuals under  
47 21 years of age, or under age 22 if they are receiving such services  
48 immediately before attaining age 21;

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

1 by a physician, for women who are at least 40 but less than 50 years  
2 of age; and one mammogram examination every year for women  
3 age 50 and over;

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

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

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

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

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

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

46 (d) Expenses for any medically appropriate and necessary  
47 supplies and equipment recommended or prescribed by a physician,  
48 advanced practice nurse, or physician assistant for the management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 No deductible, coinsurance, copayment, or any other cost-  
2 sharing requirement shall be imposed for a colonoscopy performed  
3 following a positive result on a non-colonoscopy, colorectal cancer  
4 screening test recommended by the United States Preventive  
5 Services Task Force; and

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

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

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

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

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

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

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

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

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

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

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

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

45 c. Payments for the foregoing services, goods and supplies  
46 furnished pursuant to this act shall be made to the extent authorized  
47 by this act, the rules and regulations promulgated pursuant thereto  
48 and, where applicable, subject to the agreement of insurance

1 provided for under this act. The payments shall constitute payment  
2 in full to the provider on behalf of the recipient. Every provider  
3 making a claim for payment pursuant to this act shall certify in  
4 writing on the claim submitted that no additional amount will be  
5 charged to the recipient, the recipient's family, the recipient's  
6 representative or others on the recipient's behalf for the services,  
7 goods, and supplies furnished pursuant to this act.

8 No provider whose claim for payment pursuant to this act has  
9 been denied because the services, goods, or supplies were  
10 determined to be medically unnecessary shall seek reimbursement  
11 from the recipient, his family, his representative or others on his  
12 behalf for such services, goods, and supplies provided pursuant to  
13 this act; provided, however, a provided may seek reimbursement  
14 from a recipient for services, goods, or supplies not authorized by  
15 this act, if the recipient elected to receive the services, goods or  
16 supplies with the knowledge that they were not authorized.

17 d. Any individual eligible for medical assistance (including  
18 drugs) may obtain such assistance from any person qualified to 33  
19 perform the service or services required (including an organization  
20 which provides such services, or arranges for their availability on a  
21 prepayment basis), who undertakes to provide the individual such  
22 services.

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

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

29 (1) Is an inmate of a public institution (except as a patient in a  
30 medical institution); provided, however, that an individual who is  
31 otherwise eligible may continue to receive services for the month in  
32 which he becomes an inmate, should the commissioner determine to  
33 expand the scope of Medicaid eligibility to include such an  
34 individual, subject to the limitations imposed by federal law and  
35 regulations, or

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

38 (3) Is over 21 years of age and who is receiving inpatient  
39 psychiatric hospital services in a psychiatric facility; provided,  
40 however, that an individual who was receiving such services  
41 immediately prior to attaining age 21 may continue to receive such  
42 services until the individual reaches age 22. Nothing in this  
43 subsection shall prohibit the commissioner from extending medical  
44 assistance to all eligible persons receiving inpatient psychiatric  
45 services; provided that there is federal financial participation  
46 available.

47 f. (1) A third party as defined in section 3 of P.L.1968, c.413  
48 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in

1 this or another state when determining the person's eligibility for  
2 enrollment or the provision of benefits by that third party.

3 (2) In addition, any provision in a contract of insurance, health  
4 benefits plan, or other health care coverage document, will, trust,  
5 agreement, court order, or other instrument which reduces or  
6 excludes coverage or payment for health care-related goods and  
7 services to or for an individual because of that individual's actual or  
8 potential eligibility for or receipt of Medicaid benefits shall be null  
9 and void, and no payments shall be made under this act as a result  
10 of any such provision.

11 (3) Notwithstanding any provision of law to the contrary, the  
12 provisions of paragraph (2) of this subsection shall not apply to a  
13 trust agreement that is established pursuant to 42 U.S.C.  
14 s.1396p(d)(4)(A) or (C) to supplement and augment assistance  
15 provided by government entities to a person who is disabled as  
16 defined in section 1614(a)(3) of the federal Social Security Act (42  
17 31 U.S.C. s.1382c (a)(3)).

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

20 (1) Pregnant women shall be provided prenatal care and delivery  
21 services and postpartum care, including the services cited in  
22 subsections a.(1), (3), and (5) of this section and subsections b.(1)-  
23 (10), (12), (15), and (17) of this section, and nursing facility  
24 services cited in subsection b.(13) of this section.

25 (2) Dependent children shall be provided with services cited in  
26 subsections a.(3) and (5) of this section and subsections b.(1), (2),  
27 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and  
28 nursing facility services cited in subsection b.(13) of this section.

29 (3) Individuals who are 65 years of age or older shall be  
30 provided with services cited in subsections a.(3) and (5) of this  
31 section and subsections b.(1)-(5), (6) excluding prescribed drugs,  
32 (7), (8), (10), (12), (15), and (17) of this section, and nursing  
33 facility services cited in subsection b.(13) of this section.

34 (4) Individuals who are blind or disabled shall be provided with  
35 services cited in subsections a.(3) and (5) of this section and  
36 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),  
37 3 (12), (15), and (17) of this section, and nursing facility services  
38 cited in subsection b.(13) of this section.

39 (5) (a) Inpatient hospital services, subsection a.(1) of this  
40 section, shall only be provided to eligible medically needy  
41 individuals, other than pregnant women, if the federal Department  
42 of Health and Human Services discontinues the State's waiver to  
43 establish inpatient hospital reimbursement rates for the Medicare  
44 and Medicaid programs under the authority of section 601(c)(3) of  
45 the Social Security Act Amendments of 1983, Pub.L.98-21 (42  
46 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be  
47 extended to other eligible medically needy individuals if the federal

1 Department of Health and Human Services directs that these  
2 services be included.

3 (b) Outpatient hospital services, subsection a.(2) of this section,  
4 shall only be provided to eligible medically needy individuals if the  
5 federal Department of Health and Human Services discontinues the  
6 State's waiver to establish outpatient hospital reimbursement rates  
7 for the Medicare and Medicaid programs under the authority of  
8 section 601(c)(3) of the Social Security Amendments of 1983,  
9 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital  
10 services may be extended to all or to certain medically needy  
11 individuals if the federal Department of Health and Human Services  
12 directs that these services be included. However, the use of  
13 outpatient hospital services shall be limited to clinic services and to  
14 emergency room services for injuries and significant acute medical  
15 conditions.

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

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

23 i. In the case of a specified low-income Medicare beneficiary  
24 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical  
25 assistance provided under this act shall be the payment of premiums  
26 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42  
27 U.S.C. s.1396d(p)(3)(A)(ii).

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

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

39 l. As used in paragraph (12) of subsection b. of this section,  
40 preventative care includes, but is not limited to, immunizations that  
41 have in effect a recommendation from the Department of Health,  
42 which shall in making its recommendations consider the  
43 recommendations of the Advisory Committee on Immunization  
44 Practices of the Centers for Disease Control and Prevention in the  
45 federal Department of Health and Human Services and, as  
46 appropriate, the recommendations of the American Academy of  
47 Pediatrics, the American Academy of Family Physicians, the

1 American College of Obstetricians and Gynecologists, and the  
2 American College of Physicians.

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

4

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

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

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

15 (2) immunizations that have in effect a recommendation from  
16 the **【Advisory Committee on Immunization Practices of the Centers**  
17 **for Disease Control and Prevention】** Department of Health, which  
18 shall in making its recommendations consider the recommendations  
19 of the Advisory Committee on Immunization Practices of the  
20 Centers for Disease Control and Prevention in the federal  
21 Department of Health and Human Services and, as appropriate, the  
22 recommendations of the American Academy of Pediatrics, the  
23 American Academy of Family Physicians, the American College of  
24 Obstetricians and Gynecologists, and the American College of  
25 Physicians;

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.

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

15  
16 20. Section 10 of P.L.2019, c.360 (C.52:14-17.46.6o) is amended  
17 to read as follows:

18 10. a. The School Employees' Health Benefits Commission shall  
19 ensure that every contract purchased by the commission on or after  
20 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】** Department of Health, which  
29 shall in making its recommendations consider the recommendations  
30 of the Advisory Committee on Immunization Practices of the  
31 Centers for Disease Control and Prevention in the federal  
32 Department of Health and Human Services and, as appropriate, the  
33 recommendations of the American Academy of Pediatrics, the  
34 American Academy of Family Physicians, the American College of  
35 Obstetricians and Gynecologists, and the American College of  
36 Physicians;

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

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

45 b. (1) Except as provided in paragraph (2) of this subsection,  
46 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 (cf: P.L.2019, c.360, s.10)

27

28 21. The head of each State agency shall adopt such rules and  
29 regulations, pursuant to the "Administrative Procedure Act,"  
30 P.L.1968, c.410 (C.52:14B-1 et seq.), as the head of the State  
31 agency may deem necessary, in order to replace any references to  
32 the immunization or vaccination recommendations or guidance of  
33 the Advisory Committee on Immunization Practices of the federal  
34 Centers for Disease Control and Prevention in rule or regulation  
35 with references to the recommendations of, and guidance issued by  
36 the Department of Health, which shall in making its  
37 recommendations consider the recommendations of the Advisory  
38 Committee on Immunization Practices of the Centers for Disease  
39 Control and Prevention in the federal Department of Health and  
40 Human Services and, as appropriate, the recommendations of the  
41 American Academy of Pediatrics, the American Academy of Family  
42 Physicians, the American College of Obstetricians and  
43 Gynecologists, and the American College of Physicians.

44

45 22. This act shall take effect immediately and shall apply to  
46 policies or contracts issued or renewed on or after the effective  
47 date.