

CHAPTER 361

AN ACT concerning health benefits coverage for contraceptives and amending P.L.2005, c.251.

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

1. Section 1 of P.L.2005, c.251 (C.17:48-6ee) is amended to read as follows:

C.17:48-6ee Hospital service corporation, coverage for contraceptives.

1. a. A hospital service corporation that provides hospital or medical expense benefits shall provide coverage under every contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the

contract, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those contracts in which the hospital service corporation has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

2. Section 2 of P.L.2005, c.251 (C.17:48A-7bb) is amended to read as follows:

C.17:48A-7bb Medical service corporation, coverage for contraceptives.

2. a. A medical service corporation that provides hospital or medical expense benefits shall provide coverage under every contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. This section shall apply to those contracts in which the medical service corporation has reserved the right to change the premium.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

3. Section 3 of P.L.2005, c.251 (C.17:48E-35.29) is amended to read as follows:

C.17:48E-35.29 Health service corporation, coverage for contraceptives.

3. a. A health service corporation that provides hospital or medical expense benefits shall provide coverage under every contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

- (c) Device insertion and removal;
 - (d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and
 - (e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.
- b. The coverage provided shall include prescriptions for dispensing contraceptives for:
- (1) a three-month period for the first dispensing of the contraceptive; and
 - (2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.
- c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.
- (2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).
- d. This section shall apply to those contracts in which the health service corporation has reserved the right to change the premium.
- e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

4. Section 4 of P.L.2005, c.251 (C.17B:27-46.1ee) is amended to read as follows:

C.17B:27-46.1ee Group health insurers, coverage for contraceptives.

4. a. A group health insurer that provides hospital or medical expense benefits shall provide coverage under every policy delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered

contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the policy, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

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

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

5. Section 5 of P.L.2005, c.251 (C.17B:26-2.1y) is amended to read as follows:

C.17B:26-2.1y Individual health insurer, coverage for contraceptives.

5. a. An individual health insurer that provides hospital or medical expense benefits shall provide coverage under every policy delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the policy, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

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

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

6. Section 6 of P.L.2005, c.251 (C.26:2J-4.30) is amended to read as follows:

C.26:2J-4.30 Health maintenance organization, coverage for contraceptives.

6. a. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act for a health maintenance organization, unless the health maintenance organization provides health care services for prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the health care services shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. The provisions of this section shall apply to those contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

7. Section 7 of P.L.2005, c.251 (C.17B:27A-7.12) is amended to read as follows:

C.17B:27A-7.12 Individual health benefits plan, coverage for contraceptives.

7. a. An individual health benefits plan required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall provide coverage for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the health benefits plan, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

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

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

8. Section 8 of P.L.2005, c.251 (C.17B:27A-19.15) is amended to read as follows:

C.17B:27A-19.15 Small employer health benefits plan, coverage for contraceptives.

8. a. A small employer health benefits plan required pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) shall provide coverage for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of

contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the health benefits plan, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

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

e. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

9. Section 9 of P.L.2005, c.251 (C.17:48F-13.2) is amended to read as follows:

C.17:48F-13.2 Prepaid prescription service organization; coverage for contraceptives.

9. a. A prepaid prescription service organization shall provide coverage under every contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives, and the services, drugs, devices, products, and procedures on an in-network basis as determined to be required to be covered by the commissioner pursuant to subsection b. of this section.

b. The Commissioner of Banking and Insurance shall determine, in the commissioner's discretion, which provisions of the coverage requirements applicable to insurers pursuant to P.L.2019, c.361 shall apply to prepaid prescription organizations, and shall adopt regulations in accordance with the commissioner's determination.

c. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

d. (1) Except as provided in paragraph (2) of this subsection, the benefits shall be provided to the same extent as for any other service, drug, device, product, or procedure under the contract, except no deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage shall be imposed.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

e. This section shall apply to those prepaid prescription contracts in which the prepaid prescription service organization has reserved the right to change the premium.

f. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300gg-13.

10. Section 10 of P.L.2005, c.251 (C.52:14-17.29j) is amended to read as follows:

C.52:14-17.29j SHBC, coverage for contraceptives.

10. a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act shall provide benefits for expenses incurred in the purchase of prescription female contraceptives, and the following services, drugs, devices, products, and procedures on an in-network basis:

(1) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, which coverage shall be subject to all of the following conditions:

(a) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.

(b) Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.

(c) Coverage shall be provided without any infringement upon a subscriber's choice of contraception and medical necessity shall be determined by the provider for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.

(2) Voluntary male and female sterilization.

(3) Patient education and counseling on contraception.

(4) Services related to the administration and monitoring of drugs, devices, products and services required under this section, including but not limited to:

(a) Management of side effects;

(b) Counseling for continued adherence to a prescribed regimen;

(c) Device insertion and removal;

(d) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the subscriber's health care provider; and

(e) Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service required under this section.

b. The coverage provided shall include prescriptions for dispensing contraceptives for:

(1) a three-month period for the first dispensing of the contraceptive; and

(2) a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the contract.

c. (1) Except as provided in paragraph (2) of this subsection, the contract shall specify that no deductible, coinsurance, copayment, or any other cost-sharing requirement may be imposed on the coverage required pursuant to this section.

(2) In the case of a high deductible health plan, benefits for male sterilization or male contraceptives shall be provided at the lowest deductible and other cost-sharing permitted for

a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223).

d. Nothing in this section shall limit coverage of any additional preventive service for women, as identified or recommended by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services pursuant to the provisions of 42 U.S.C. 300g-13.

11. This act shall take effect on the 90th day next following enactment and shall apply to policies or contracts issued or renewed on or after the effective date.

Approved January 16, 2020.