CHAPTER 105

AN ACT concerning cost sharing for certain prescription drugs, amending P.L.1995, c.331, and supplementing various parts of the statutory law.

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

1. Section 1 of P.L.1995, c.331 (C.17:48-6n) is amended to read as follows:

C.17:48-6n Coverage, diabetes treatment, individual, group hospital service corporation.

1. a. Every individual or group hospital service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act shall provide benefits to any subscriber or other person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this subsection shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this subsection shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this subsection shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

b. Each individual or group hospital service corporation contract shall also provide benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Benefits provided for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes; upon diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the subscriber's or other covered person's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary. Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

c. The benefits required by this section shall be provided to the same extent as for any other sickness under the contract.

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

e. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

f. The Commissioner of Banking and Insurance may, in consultation with the Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

C.17:48-6xx Individual, group hospital service corporation contract, coverage, epinephrine auto-injector device.

2. An individual or group hospital service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a hospital service corporation from reducing a subscriber’s or other covered person’s cost-sharing requirement by an amount greater than the amount specified in this section.

C.17:48-6yy Individual, group hospital service corporation contract, coverage, prescription asthma inhaler.

3. An individual or group hospital service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide benefits to a subscriber or other person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal

Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a hospital service corporation from reducing a subscriber's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

4. Section 2 of P.L.1995, c.331 (C.17:48A-7l) is amended to read as follows:

C.17:48A-7l Coverage, diabetes treatment, individual, group medical service corporation.

2. a. Every individual or group medical service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act shall provide benefits to any subscriber or other person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this subsection shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this subsection shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this subsection shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

b. Each individual or group medical service corporation contract shall also provide benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Benefits provided for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes; upon diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the subscriber's or other covered person's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary. Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered

pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

c. The benefits required by this section shall be provided to the same extent as for any other sickness under the contract.

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

e. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

f. The Commissioner of Banking and Insurance may, in consultation with the Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

C.17:48A-7uu Individual, group medical service corporation contract, coverage, epinephrine auto-injector device.

5. An individual or group medical service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a medical service corporation from reducing a subscriber’s or other covered person’s cost-sharing requirement by an amount greater than the amount specified in this section.

C.17:48A-7vv Individual, group medical service corporation contract, coverage, prescription asthma inhaler.

6. An individual or group medical service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide benefits to a subscriber or other person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible,

and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a medical service corporation from reducing a subscriber's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

7. Section 3 of P.L.1995, c.331 (C.17:48E-35.11) is amended to read as follows:

C.17:48E-35.11 Coverage for diabetes treatment by individual group health service corporation.

3. a. Every individual or group health service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act shall provide benefits to any subscriber or other person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this subsection shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this subsection shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this subsection shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

b. Each individual or group health service corporation contract shall also provide benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Benefits provided for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes; upon the diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the subscriber's or other covered person's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a physician or

nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary. Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

c. The benefits required by this section shall be provided to the same extent as for any other sickness under the contract.

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

e. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

f. The Commissioner of Banking and Insurance may, in consultation with the Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

C.17:48E-35.48 Individual, group health service corporation contract, coverage, epinephrine auto-injector device.

8. An individual or group health service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a health service corporation from reducing a subscriber’s or other covered person’s cost-sharing requirement by an amount greater than the amount specified in this section.

C.17:48E-35.49 Individual, group health service corporation contract, coverage, prescription asthma inhaler.

9. An individual or group health service corporation contract providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105

(C.17:48-6xx et al.) shall provide benefits to a subscriber or other person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a health service corporation contract from reducing a subscriber's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

10. Section 4 of P.L.1995, c.331 (C.17B:26-2.1l) is amended to read as follows:

C.17B:26-2.1l Coverage, diabetes treatment, individual health insurance policy.

4. a. Every individual health insurance policy providing hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to Chapter 26 of Title 17B of the New Jersey Statutes or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act shall provide benefits to any person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this subsection shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this subsection shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this subsection shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

b. Each individual health insurance policy shall also provide benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Benefits provided for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes;

upon diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change in the covered person's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary. Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

c. The benefits required by this section shall be provided to the same extent as for any other sickness under the policy.

d. This section shall apply to all individual health insurance policies in which the insurer has reserved the right to change the premium.

e. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

f. The Commissioner of Banking and Insurance may, in consultation with the Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

C.17B:26-2.1qq Individual health insurance policy, coverage, epinephrine auto-injector device.

11. An individual health insurance policy providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to Chapter 26 of Title 17B of the New Jersey Statutes or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent an individual health insurer from reducing a covered person’s cost-sharing requirement by an amount greater than the amount specified in this section.

C.17B:26-2.1rr Individual health insurance policy, coverage, prescription asthma inhaler.

12. An individual health insurance policy providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to Chapter 26 of Title 17B of the New Jersey Statutes or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105

(C.17:48-6xx et al.) shall provide benefits to a person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent an individual health insurer from reducing a covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

13. Section 5 of P.L.1995, c.331 (C.17B:27-46.1m) is amended to read as follows:

C.17B:27-46.1m Coverage, diabetes treatment, group health insurance policy.

5. a. Every group health insurance policy providing hospital or medical expense benefits that is delivered, issued, executed or renewed in this State pursuant to Chapter 27 of Title 17B of the New Jersey Statutes or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act shall provide benefits to any person covered thereunder for expenses incurred for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this subsection shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this subsection shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this subsection shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

b. Each group health insurance policy shall also provide benefits for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Benefits provided for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes; upon diagnosis by a physician or nurse practitioner/clinical nurse specialist of a significant change

in the covered person's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary. Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

c. The benefits required by this section shall be provided to the same extent as for any other sickness under the policy.

d. This section shall apply to all group health insurance policies in which the insurer has reserved the right to change the premium.

e. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

f. The Commissioner of Banking and Insurance may, in consultation with the Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

C.17B:27-46.1ww Group health insurance policy, coverage, epinephrine auto-injector device.

14. A group health insurance policy providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to Chapter 27 of Title 17B of the New Jersey Statutes or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a group health insurer from reducing a covered person’s cost-sharing requirement by an amount greater than the amount specified in this section.

C.17B:27-46.1xx Group health insurance policy, coverage, prescription asthma inhaler.

15. A group health insurance policy providing hospital or medical expense benefits that is delivered, issued, executed, or renewed in this State pursuant to Chapter 27 of Title 17B of the New Jersey Statutes or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide benefits to a person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating

nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a group health insurer from reducing a covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

16. Section 6 of P.L.1995, c.331 (C.26:2J-4.11) is amended to read as follows:

C.26:2J-4.11 Coverage, diabetes treatment by HMO contracts.

6. a. Every contract for health care services that is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State on or after the effective date of this act shall provide health care services to any enrollee or other person covered thereunder for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this subsection shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this subsection shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this subsection shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

b. Each contract shall also provide health care services for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Health care services provided for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes; upon diagnosis by a participating physician or participating nurse practitioner/clinical nurse specialist of a significant change in the enrollee's or other covered person's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a participating physician or participating nurse practitioner/clinical nurse specialist that reeducation or refresher education

is necessary. Diabetes self-management education shall be provided by a participating dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or, pursuant to section 6 of P.L.1993, c.378 (C.26:2J-4.7), a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

c. The health care services required by this section shall be provided to the same extent as for any other sickness under the contract.

d. This section shall apply to all contracts in which the health maintenance organization has reserved the right to change the schedule of charges.

e. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

f. The Commissioner of Banking and Insurance may, in consultation with the Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate and periodically update a list of additional diabetes equipment and related supplies that are medically necessary for the treatment of diabetes and for which benefits shall be provided according to the provisions of this section.

C.26:2J-4.49 Contract, health care services, coverage, epinephrine auto-injector device.

17. A contract for health care services that is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a health maintenance organization from reducing an enrollee’s or other covered person’s cost-sharing requirement by an amount greater than the amount specified in this section.

C.26:2J-4.50 Contract, health care services, coverage, prescription asthma inhaler.

18. A contract for health care services that is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) shall provide benefits to an enrollee or other person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per

30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a health maintenance organization from reducing an enrollee's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

C.17B:27A-7.31 Individual health benefits plan, coverage, insulin for diabetes treatment.

19. An individual health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et al.), on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage to an enrollee or other person covered thereunder for insulin for the treatment of diabetes, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

The benefits shall be provided to the same extent as for any other condition under the health benefits plan.

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

C.17B:27A-7.32 Individual health benefits plan, coverage, epinephrine auto-injector device.

20. An individual health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et al.), on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to

section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a carrier from reducing an enrollee's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

C.17B:27A-7.33 Individual health benefits plan, coverage, prescription asthma inhaler.

21. An individual health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et al.), on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide benefits to an enrollee or other person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a carrier from reducing an enrollee's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

C.17B:27A-19.35 Small employer health benefits plan, coverage, insulin for diabetes treatment.

22. A small employer health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage to an enrollee or other person covered thereunder for insulin for the treatment of diabetes, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions

of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

The benefits shall be provided to the same extent as for any other condition under the health benefits plan.

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

C.17B:27A-19.36 Small employer health benefits plan, coverage, epinephrine auto-injector device.

23. A small employer health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a carrier from reducing an enrollee's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

The benefits shall be provided to the same extent as for any other condition under the health benefits plan.

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

C.17B:27A-19.37 Small employer health benefits plan, coverage, prescription asthma inhaler.

24. A small employer health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide benefits to an enrollee or other person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply. The provisions of this section shall apply to a high-deductible health plan to the maximum extent permitted by federal law, except if the plan is used to establish a medical savings account pursuant to section 220 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.220) or a health savings account pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223). The provisions of this section shall apply to the plan to the maximum extent that is permitted by federal law and does not disqualify the account for the deduction allowed under section 220 or 223, as applicable. The provisions of this section

shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent a carrier from reducing an enrollee's or other covered person's cost-sharing requirement by an amount greater than the amount specified in this section.

The benefits shall be provided to the same extent as for any other condition under the health benefits plan.

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

C.52:14-17.29kk State Health Benefits Commission, ensure, contract purchased, renewed, coverage, insulin for diabetes treatment.

25. The State Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage for health care services to a person covered thereunder for insulin for the treatment of diabetes, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply, except a contract provided by the State Health Benefits Commission that qualifies as a high-deductible health plan shall provide coverage for the purchase of insulin at the lowest deductible and other cost-sharing requirement permitted for a high-deductible health plan under section 223(c)(2)(A) of the federal Internal Revenue Code (26 U.S.C. s.223 (c)(2)(A)). The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent the State Health Benefits Commission from reducing an enrollee's cost-sharing requirement by an amount greater than the amount specified in this section or prevent the commission from utilizing formulary management, including a mandatory generic policy, to promote the use of lower-cost alternative generic drugs that are the therapeutic equivalent of the brand-name drug, which could result in the member's copay being higher than set forth in this section.

C.52:14-17.29ll State Health Benefits Commission, ensure, contract purchased, renewed, coverage, epinephrine auto-injector device.

26. The State Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply, except a contract provided by the State Health Benefits Commission that qualifies as a high-deductible health plan shall provide coverage for the purchase of an epinephrine auto-injector device at the lowest deductible and other cost-sharing requirement permitted for a high-deductible health plan under section 223(c)(2)(A) of the federal Internal Revenue Code (26 U.S.C. s.223 (c)(2)(A)). The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent the State Health Benefits Commission from reducing a covered person's cost-sharing requirement by an amount greater than the amount specified in this section or prevent the commission from utilizing formulary management, including a mandatory generic policy, to promote the use of lower-cost alternative generic drugs that are the therapeutic equivalent of the brand-name drug, which could result in the member's copay being higher than set forth in this section.

C.52:14-17.29mm State Health Benefits Commission, ensure, contract purchased, renewed, coverage, prescription asthma inhaler.

27. The State Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide benefits to a person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply, except a contract provided by the State Health Benefits Commission that qualifies as a high-deductible health plan shall provide coverage for the purchase of a covered prescription asthma inhaler at the lowest deductible and other cost-sharing requirement permitted for a high-deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223). The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent the State Health Benefits Commission from reducing a covered person's cost-sharing requirement by an amount greater than the amount specified in this section or prevent the commission from utilizing formulary management, including a mandatory generic policy, to promote the use of lower-cost alternative generic drugs that are the therapeutic equivalent of the brand-name drug, which could result in the member's copay being higher than set forth in this section.

C.52:14-17.46.6s School Employees' Health Benefits Commission, ensure, contract purchased, health care services, insulin for diabetes treatment.

28. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.) that provides hospital and medical expense benefits shall provide health care services to a person covered thereunder for insulin for the treatment of diabetes, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply, except a contract provided by the School Employees' Health Benefits Commission that qualifies as a high-deductible health plan shall provide coverage for the purchase of insulin at the lowest deductible and other cost-sharing requirement permitted for a high-deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223 (c)(2)(A)). The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent the School Employees' Health Benefits Commission from reducing an enrollee's cost-sharing requirement by an amount greater than the amount

specified in this section or prevent the commission from utilizing formulary management, including a mandatory generic policy, to promote the use of lower-cost alternative generic drugs that are the therapeutic equivalent of the brand-name drug, which could result in the member’s copay being higher than set forth in this section.

C.52:14-17.46.6t School Employees' Health Benefits Commission, ensure, contract purchased, renewed, coverage, epinephrine auto-injector device.

29. The School Employees' Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide coverage for at least one epinephrine auto-injector device, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of an epinephrine auto-injector device shall not be subject to any deductible, and no copayment or coinsurance for the purchase of an epinephrine auto-injector device shall exceed $25 per 30-day supply, except a contract provided by the School Employees' Health Benefits Commission that qualifies as a high-deductible health plan shall provide coverage for the purchase of an epinephrine auto-injector device at the lowest deductible and other cost-sharing requirement permitted for a high-deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223 (c)(2)(A)). The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent the School Employees' Health Benefits Commission from reducing an enrollee's cost-sharing requirement by an amount greater than the amount specified in this section or prevent the commission from utilizing formulary management, including a mandatory generic policy, to promote the use of lower-cost alternative generic drugs that are the therapeutic equivalent of the brand-name drug, which could result in the member’s copay being higher than set forth in this section.

C.52:14-17.46.6u School Employees' Health Benefits Commission, ensure, contract purchased, renewed, benefits, covered, expenses, prescription asthma inhaler.

30. The School Employees' Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2023, c.105 (C.17:48-6xx et al.), shall provide benefits to a person covered thereunder for expenses incurred for a prescription asthma inhaler, if recommended or prescribed by a participating physician or participating nurse practitioner/clinical nurse specialist. Coverage for the purchase of a covered prescription asthma inhaler shall not be subject to any deductible, and no copayment or coinsurance for the purchase of a covered prescription asthma inhaler shall exceed $50 per 30-day supply, except a contract provided by the School Employees' Health Benefits Commission that qualifies as a high-deductible health plan shall provide coverage for the purchase of a covered prescription asthma inhaler at the lowest deductible and other cost-sharing requirement permitted for a high-deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code (26 U.S.C. s.223 (c)(2)(A)). The provisions of this section shall apply to a plan that meets the requirements of a catastrophic plan, as defined in 45 C.F.R. s.156.155, to the maximum extent permitted by federal law.

Nothing in this section shall prevent the School Employees' Health Benefits Commission from reducing a covered person’s cost-sharing requirement by an amount greater than the amount specified in this section or prevent the commission from utilizing formulary management, including a mandatory generic policy, to promote the use of lower-cost

alternative generic drugs that are the therapeutic equivalent of the brand-name drug, which could result in the member's copay being higher than set forth in this section.

31. This act shall take effect on the first day of the seventh month next following the date of enactment and shall apply to plans issued or renewed on or after January 1 of the next calendar year, but the Commissioner of the Department of Banking and Insurance may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the act.

Approved July 10, 2023.