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SECOND REPRINT **S.B. 233**

SENATE BILL NO. 233–SENATORS RATTI, CANCELA, SPEARMAN, CANNIZZARO, WOODHOUSE; ATKINSON, DENIS, FORD, MANENDO, PARKS AND SEGERBLOM

MARCH 1, 2017

JOINT SPONSOR: ASSEMBLYWOMAN BENITEZ-THOMPSON

Referred to Committee on Health and Human Services

SUMMARY—Requires the State Plan for Medicaid and certain health insurance plans to provide certain benefits. (BDR 38-817)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

CONTAINS UNFUNDED MANDATE (§§ 7, 8)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to health care; requiring the State Plan for Medicaid and certain health insurance plans to provide certain benefits relating to reproductive health care, hormone replacement therapy and preventative health care; revising provisions relating to dispensing of contraceptives; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires most health insurance plans which cover prescription drugs and outpatient care to also include coverage for contraceptive drugs and devices without an additional copay, coinsurance or a higher deductible than that which may be charged for other prescription drugs and outpatient care under the plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 695B.1918, 695C.1694, 695C.1695) Existing law also requires most health insurance plans to include coverage for certain preventative services, including the human papillomavirus vaccine, cytological screenings and mammograms. (NRS 287.0272, 689A.0405, 689A.044, 689B.0313, 689B.0374, 695B.1912, 695B.1925, 695C.1735, 695C.1745, 695G.171) Certain plans, including small employer plans, benefit contracts provided by fraternal benefit societies, plans issued by a managed care organization and certain plans offered by governmental entities of this State

are not currently subject to some of these requirements. (Chapters 287, 689C, 695A and 695G of NRS)

The federal Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires certain preventative services to be covered by every health insurance plan without any copay, coinsurance or higher deductible, including, without limitation, certain contraceptive drugs, devices and services, certain vaccinations, mammograms, counseling concerning interpersonal and domestic violence, screenings for certain diseases and well-woman preventative visits. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) This bill places those requirements in Nevada law, requiring all private health insurance plans and certain public health insurance plans made available in this State to provide coverage for certain preventative services without any copay, coinsurance or a higher deductible. **Sections 7, 8 and 11-57** of this bill allow an insurer to require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refused to accept a therapeutic equivalent of the contraceptive drug. In addition, a health insurance plan must include for each listed method of contraception which is approved by the Food and Drug Administration at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the insured. **Sections 7, 8 and 11-57** authorize an insurer to use medical management techniques, including step therapy and prior authorization, to determine the frequency of the preventative services required by this bill or the type of provider of health care who will provide such services. **Sections 7, 8 and 11-57** also require certain contraceptive drugs, devices and services to be covered by a health insurance plan, including up to a 12-month supply of contraceptives or a therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception and voluntary sterilization for women. **Sections 12, 18, 27, 33, 38, 45 and 54**: (1) prohibit the use of medical management techniques to require an insured to use a method of contraception other than that prescribed or ordered by a provider of health care; and (2) require an insurer to provide a process by which an insured can request an exemption from a medical management technique required by an insurer to obtain contraception.

Existing law authorizes an insurer which is affiliated with a religious organization and which objects on religious grounds to providing coverage for contraceptive drugs and devices to exclude coverage in its policies, plans or contracts for such drugs and devices. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 695B.1918, 695C.1694, 695C.1695) **Sections 12, 20, 27, 33, 38, 45 and 54** of this bill move the religious exemption to the new provisions relating to coverage of contraception.

Existing law requires most health insurance plans which cover prescription drugs and outpatient care to also include coverage for hormone replacement therapy without an additional copay, coinsurance or a higher deductible than that which may be charged for other prescription drugs and outpatient care under the plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 695B.1918, 695C.1694, 695C.1695) **Sections 7, 8 and 11-57** of this bill expand this requirement to private health insurance plans and certain public health insurance plans made available in this State and require such health insurance plans to provide coverage for hormone replacement therapy without any copay, coinsurance or higher deductible.

Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a state to charge a copay, coinsurance or deductible for most Medicaid services, but prohibits any copay, coinsurance or deductible for certain contraceptive drugs, devices and services. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a state to define the parameters of contraceptive coverage provided under Medicaid.

(42 U.S.C. § 1396u-7) Existing law requires a number of specific medical services to be covered under Medicaid. (NRS 422.2717-422.27241) **Sections 2-5.5** of this bill require the State Plan for Medicaid to include the preventative services currently required to be covered by private health insurance plans pursuant to existing Nevada law, the Patient Protection and Affordable Care Act (Public Law 111-148 as amended) as well as the additional drugs, devices, supplies and services required by **sections 7, 8 and 11-57** without any copay, coinsurance or deductible in most cases. The benefits relating to contraceptive drugs which are provided by **section 2** of this bill are subject to step therapy and prior authorization requirements pursuant to existing law.

Existing law authorizes a pharmacist to dispense up to a 90-day supply of a drug pursuant to a valid prescription or order in certain circumstances. (NRS 639.2396) **Section 8.5** of this bill requires a pharmacist to dispense up to a 12-month or the balance of the plan year, whichever is shorter, supply of contraceptives or their therapeutic equivalent pursuant to a valid prescription or order if: (1) the patient has previously received a 3-month supply of the same drug; (2) the patient has previously received a 9-month supply of the same drug or a supply of the same drug for the balance of the plan year in which the 3-month supply was prescribed or ordered, whichever is shorter; (3) the patient is insured by the same health insurance plan; and (4) a provider of health care has not specified in the prescription or order that a different supply of the drug is necessary.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 4.5, inclusive, of this act.

Sec. 2. ***1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Dispensed in accordance with section 8.5 of this act.

(b) Any type of device for contraception which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;

(c) Insertion or removal of a device for contraception;

(d) Education and counseling relating to the initiation of the use of contraceptives and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit provided in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. The Director shall ensure that the provisions of this section are carried out in a manner which complies with the requirements established by the Drug Use Review Board and set forth in the list of preferred prescription drugs established by the Department pursuant to NRS 422.4025.

4. The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug.

5. For each method of contraception which is approved by the Food and Drug Administration, the Plan must include at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the person enrolled in Medicaid, but the Plan may charge a deductible, copayment or coinsurance for any other contraceptive drug or device that provides the same method of contraception.

6. As used in this section, "therapeutic equivalent" means a drug which:

(a) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(b) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(c) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 3. *1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Counseling and support for breastfeeding;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Screening for blood pressure abnormalities and diabetes, including gestational diabetes;

(e) An annual screening for cervical cancer;

(f) Screening for depression;

(g) Screening and counseling for the human immunodeficiency virus;

(h) Smoking cessation programs, including not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each per year;

(i) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(j) Such well-woman preventative visits as recommended by the Health Resources and Services Administration; and

(k) Hormone replacement therapy.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

Sec. 4. ***1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for a mammogram not less than once every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.***

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 4.5. ***The Director may include in the State Plan for Medicaid a requirement that, to the extent money is available, the State pay the nonfederal share of expenditures incurred for:***

1. Supplies for breastfeeding; and

2. Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization.

Sec. 5. NRS 422.2718 is hereby amended to read as follows:

422.2718 1. The Director shall include in the State Plan for Medicaid a requirement that the State shall pay the nonfederal share of expenses incurred for ~~[administering]~~ ***:***

(a) Testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine ~~[to women and girls]~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ***To obtain the services listed in subsection 1, a person enrolled in Medicaid must not be required to:***

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration to be used for the prevention of human papillomavirus infection and cervical cancer.

Sec. 5.5. NRS 422.401 is hereby amended to read as follows:

422.401 As used in NRS 422.401 to 422.406, inclusive, ***and sections 2 to 4.5, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 422.4015 and 422.402 have the meanings ascribed to them in those sections.

Sec. 5.7. NRS 422.406 is hereby amended to read as follows:

422.406 1. The Department may, to carry out its duties set forth in NRS 422.401 to 422.406, inclusive, ***and sections 2 to 4.5, inclusive, of this act,*** and to administer the provisions of NRS 422.401 to 422.406, inclusive ~~[.]~~ ***, and sections 2 to 4.5, inclusive, of this act:***

(a) Adopt regulations; and

(b) Enter into contracts for any services.

2. Any regulations adopted by the Department pursuant to NRS 422.401 to 422.406, inclusive, ***and sections 2 to 4.5, inclusive, of this act,*** must be adopted in accordance with the provisions of chapter 241 of NRS.

Sec. 6. (Deleted by amendment.)

Sec. 7. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and

employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and sections 20 and 21 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph ~~[.]~~ ***, except that the provisions of sections 20 and 21 of this act only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.***

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school

district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 8. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and sections 54, 55 and 56 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 8.5. Chapter 639 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsections 2 and 3, pursuant to a valid prescription or order for a drug to be used for contraception or its therapeutic equivalent which has been approved by the Food and Drug Administration a pharmacist shall:

(a) The first time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 3-month supply of the drug or therapeutic equivalent.

(b) The second time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 9-month supply of the drug or therapeutic equivalent, or any amount which covers the

remainder of the plan year if the patient is covered by a health care plan, whichever is less.

(c) For a refill in a plan year following the initial dispensing of a drug or therapeutic equivalent pursuant to paragraphs (a) and (b), dispense up to a 12-month supply of the drug or therapeutic equivalent or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.

2. The provisions of paragraphs (b) and (c) of subsection 1 only apply if:

(a) The drug for contraception or the therapeutic equivalent of such drug is the same drug or therapeutic equivalent which was previously prescribed or ordered pursuant to paragraph (a) of subsection 1; and

(b) The patient is covered by the same health care plan.

3. If a prescription or order for a drug for contraception or its therapeutic equivalent limits the dispensing of the drug or therapeutic equivalent to a quantity which is less than the amount otherwise authorized to be dispensed pursuant to subsection 1, the pharmacist must dispense the drug or therapeutic equivalent in accordance with the quantity specified in the prescription or order.

4. As used in this section:

(a) "Health care plan" means a policy, contract, certificate or agreement offered or issued by an insurer, including without limitation, the State Plan for Medicaid, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(b) "Plan year" means the year designated in the evidence of coverage of a health care plan in which a person is covered by such plan.

(c) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 9. NRS 639.2396 is hereby amended to read as follows:

639.2396 1. Except as otherwise provided by subsection 2, a prescription which bears specific authorization to refill, given by the prescribing practitioner at the time he or she issued the original prescription, or a prescription which bears authorization permitting the pharmacist to refill the prescription as needed by the patient, may be refilled for the number of times authorized or for the period

authorized if it was refilled in accordance with the number of doses ordered and the directions for use.

2. ~~[~~A~~]~~ ***Except as otherwise provided in section 8.5 of this act, a*** pharmacist may, in his or her professional judgment and pursuant to a valid prescription that specifies an initial amount of less than a 90-day supply of a drug other than a controlled substance followed by periodic refills of the initial amount of the drug, dispense not more than a 90-day supply of the drug if:

(a) The patient has used an initial 30-day supply of the drug or the drug has previously been prescribed to the patient in a 90-day supply;

(b) The total number of dosage units that are dispensed pursuant to the prescription does not exceed the total number of dosage units, including refills, that are authorized on the prescription by the prescribing practitioner; and

(c) The prescribing practitioner has not specified on the prescription that dispensing the prescription in an initial amount of less than a 90-day supply followed by periodic refills of the initial amount of the drug is medically necessary.

3. Nothing in this section shall be construed to alter the coverage provided under any contract or policy of health insurance, health plan or program or other agreement arrangement that provides health coverage.

Sec. 10. (Deleted by amendment.)

Sec. 11. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 12 and 13 of this act.

Sec. 12. ***1. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall include in the policy coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 8; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 8;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same policy of health insurance;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; and

(e) Voluntary sterilization for women.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsections 6, 7 and 9, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. Except as otherwise provided in subsection 5, a policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. An insurer that offers or issues a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

6. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

7. For each of the 18 methods of contraception listed in subsection 8 that has been approved by the Food and Drug

Administration, a policy of health insurance must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

8. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Antiprogestin-based drugs for emergency contraception.

9. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

10. An insurer shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

11. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the insurer to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

12. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 13. *1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually with intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(i) Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 14. NRS 689A.0405 is hereby amended to read as follows:

689A.0405 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for ~~[~~:

~~(a) An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40; and~~

~~(c) An annual~~~~]~~ ***a*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older.

2. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~[3.]~~ ***4.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 15. NRS 689A.0415 is hereby amended to read as follows:

689A.0415 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any~~ ***any*** type of hormone replacement therapy ~~, ➥~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a policy of health insurance that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for ~~a contraceptive or~~ hormone replacement therapy ***;*** ~~than is required for other prescription drugs covered by the policy;~~

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~any of the services listed in subsection 1;~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~any of the services listed in subsection 1;~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~any of the services listed in subsection 1~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~any of the services listed in subsection 1~~ ***hormone replacement therapy*** to an insured.

3. ~~Except as otherwise provided in subsection 5, a~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not ~~:~~

~~(a) Require~~ ***require*** an insurer to provide coverage for fertility drugs.

~~(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the policy.~~

5. ~~An insurer which offers or issues a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and~~

~~before the renewal of such a policy, provide to the prospective insured, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.~~

~~6.~~] As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 16. NRS 689A.0417 is hereby amended to read as follows:

689A.0417 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. An insurer that offers or issues a policy of health insurance that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy ***;*** ~~[than is required for other outpatient care covered by the policy;]~~

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. ~~[The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the~~

~~same as the insured is required to pay for other outpatient care covered by the policy.~~

~~5. An insurer which offers or issues such a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.~~

~~6.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 17. NRS 689A.044 is hereby amended to read as follows:

689A.044 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~[~~3.~~]~~ ***4.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[~~July 1, 2007,~~]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[~~subsection 1~~]~~ ***this section*** is void.

~~[~~4. For the purposes of~~]~~

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~[~~, "human~~]~~ ***:***

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 18. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[~~.~~]~~ ***, and sections 12 and 13 of this act.***

Sec. 19. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 20 and 21 of this act.

Sec. 20. *1. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 9; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 9;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same policy of group health insurance;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; and

(e) Voluntary sterilization for women.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsections 7, 8 and 10, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny,

reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. Except as otherwise provided in subsection 5, a policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. An insurer that offers or issues such a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

7. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

8. For each of the 18 methods of contraception listed in subsection 9 that has been approved by the Food and Drug Administration, a policy of group health insurance must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

9. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
(r) Antiprogestin-based drugs for emergency contraception.

10. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

11. An insurer shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

12. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the insurer to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

13. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 21. *1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(i) Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical

care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 22. NRS 689B.0313 is hereby amended to read as follows:

689B.0313 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~[3.]~~ ***4.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of]~~

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~[, "human]~~ ***:***

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 23. NRS 689B.0374 is hereby amended to read as follows:

689B.0374 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for ~~[:~~

~~(a) An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40;and~~

~~(c) An annual]~~ ***a*** mammogram ***every 2 years, or annually if ordered by provider of health care,*** for women 40 years of age or older.

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~[3.]~~ ***4.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the

use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 24. NRS 689B.0376 is hereby amended to read as follows:

689B.0376 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~

~~"]~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a policy of group health insurance that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for ~~[a contraceptive or]~~ hormone replacement therapy ***;*** ~~[than is required for other prescription drugs covered by the policy;]~~

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for

delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not ~~[:~~

~~(a) Require]~~ ***require*** an insurer to provide coverage for fertility drugs.

~~[(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the policy.]~~

5. ~~[An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 25. NRS 689B.0377 is hereby amended to read as follows:

689B.0377 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of group health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. An insurer that offers or issues a policy of group health insurance that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy ***;*** ~~[than is required for other outpatient care covered by the policy;]~~

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

~~4. [The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the policy.~~

~~5. An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 26. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 27 to 30, inclusive, of this act.

Sec. 27. *1. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall include in the plan coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 8; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 8;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same health benefit plan;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; and

(e) Voluntary sterilization for women.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsections 6, 7 and 9, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. Except as otherwise provided in subsection 5, a health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. A carrier that offers or issues a health benefit plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the carrier objects on religious grounds. Such a carrier shall, before the issuance of a health benefit plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the carrier refuses to provide pursuant to this subsection.

6. A carrier may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

7. For each of the 18 methods of contraception listed in subsection 8 that has been approved by the Food and Drug Administration, a health benefit plan must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the carrier may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

8. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Antiprogestin-based drugs for emergency contraception.

9. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

10. A carrier shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

11. A carrier must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the carrier to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

12. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 28. *1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Hormone replacement therapy;

(e) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(f) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(g) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(j) Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;

(k) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 29. *1. A health benefit plan must provide coverage for benefits payable for expenses incurred for:*

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit

required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 30. *1. A health benefit plan must provide coverage for benefits payable for expenses incurred for a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.*

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny,

reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 31. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 27 to 30, inclusive, of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 32. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 33 to 36, inclusive, of this act.

Sec. 33. ***1. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract which provides coverage for prescription drugs or devices shall include in the contract coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;
(2) Approved by the Food and Drug Administration;
(3) Listed in subsection 8; and
(4) Dispensed in accordance with section 8.5 of this act;
(b) Any type of device for contraception which is:
(1) Lawfully prescribed or ordered;
(2) Approved by the Food and Drug Administration; and
(3) Listed in subsection 8;
(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same benefit contract;
(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; and
(e) Voluntary sterilization for women.
2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.
3. Except as otherwise provided in subsections 6, 7 and 9, a society that offers or issues a benefit contract shall not:
(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;
(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use any such benefit;
(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;
(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;
(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or
(f) Impose any other restrictions or delays on the access of an insured to any such benefit.
4. Except as otherwise provided in subsection 5, a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. A society that offers or issues a benefit contract and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the society objects on religious grounds. Such a society shall, before the issuance of a benefit contract and before the renewal of such a contract, provide to the prospective insured written notice of the coverage that the society refuses to provide pursuant to this subsection.

6. A society may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

7. For each of the 18 methods of contraception listed in subsection 8 that has been approved by the Food and Drug Administration, a benefit contract must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the society may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

8. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Antiprogestin-based drugs for emergency contraception.

9. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit

required by this section or the type of provider of health care to use for such treatment.

10. A society shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

11. A society must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the society to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

12. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 34. *1. A society that offers or issues a benefit contract shall include in the contract coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Hormone replacement therapy;

(e) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(f) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(g) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(j) Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;

(k) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 35. *1. A benefit contract must provide coverage for benefits payable for expenses incurred for:*

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age and older; and

(b) Administering the human papillomavirus vaccine, as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the

use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 36. *1. A benefit contract must provide coverage for benefits payable for expenses incurred for a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.*

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit provided in a benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques,

including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 37. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 38 and 39 of this act.

Sec. 38. *1. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 9; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 9;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same contract for hospital or medical service;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; and

(e) Voluntary sterilization for women.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsections 7, 8 and 10, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. Except as otherwise provided in subsection 5, a contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. An insurer that offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

7. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

8. For each of the 18 methods of contraception listed in subsection 9 that has been approved by the Food and Drug Administration, a contract for hospital or medical service must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

9. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Antiprogestin-based drugs for emergency contraception.

10. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

11. An insurer shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

12. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the insurer to obtain any benefit required by

this section without a higher deductible, copayment or coinsurance.

13. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 39. *1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(i) Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny,

reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 40. NRS 695B.1912 is hereby amended to read as follows:

695B.1912 1. ~~[A policy of health insurance issued by a hospital or medical service corporation]~~ ***An insurer that offers or issues a contract for hospital or medical service*** must provide coverage for benefits payable for expenses incurred for ~~[:~~

~~(a) An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40; and~~

~~(c) An annual]~~ ***a*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older.

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior~~

~~authorization for any service provided pursuant to subsection 1.~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in a contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~3.~~ ***4.*** A ~~policy~~ ***contract for hospital or medical service*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989,~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the ~~policy~~ ***contract*** or the renewal which is in conflict with ~~subsection 1~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 41. NRS 695B.1916 is hereby amended to read as follows:

695B.1916 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a contract for hospital or medical service which provides coverage for prescription drugs or devices shall include in the contract coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~

~~"]~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a contract for hospital or medical service that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for ~~[a contraceptive or]~~ hormone replacement therapy ***;*** ~~[than is required for other prescription drugs covered by the contract;]~~

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** contract ***for hospital or medical service*** subject to the provisions of this

chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

4. The provisions of this section do not ~~[~~:

~~(a) Require]~~ ***require*** an insurer to provide coverage for fertility drugs.

~~[(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the contract.]~~

5. ~~[An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 42. NRS 695B.1918 is hereby amended to read as follows:

695B.1918 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a contract for hospital or medical service which provides coverage for outpatient care shall include in the contract coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. An insurer that offers or issues a contract for hospital or medical service that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy ***;*** ~~[than is required for other outpatient care covered by the contract;]~~

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** contract ***for hospital or medical service*** subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

~~4. [The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the contract.~~

~~5. An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 43. NRS 695B.1925 is hereby amended to read as follows:

695B.1925 1. ~~[A policy of health insurance issued by a hospital or medical service corporation]~~ ***An insurer that offers or issues a contract for hospital or medical service*** must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age and older; and

(b) Administering the human papillomavirus vaccine ~~[to women and girls]~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. Except as otherwise required by subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~[3.]~~ ***4.*** A ~~[policy]~~ ***contract for hospital or medical service*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the ~~[policy]~~ ***contract*** or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of]~~

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~[, "human]~~ ***:***

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 44. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 45 and 46 of this act.

Sec. 45. ***1. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 9; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 9;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the enrollee was covered by the same health care plan;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; and

(e) Voluntary sterilization for women.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsections 7, 8 and 10, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. Except as otherwise provided in subsection 5, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. A health maintenance organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by

subsection 1 if the health maintenance organization objects on religious grounds. Such an organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.

6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

7. A health maintenance organization may require an enrollee to pay a higher deductible, copayment or coinsurance for a drug for contraception if the enrollee refuses to accept a therapeutic equivalent of the drug.

8. For each of the 18 methods of contraception listed in subsection 9 that has been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the enrollee, but the health maintenance organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

9. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Antiprogestin-based drugs for emergency contraception.

10. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

11. A health maintenance organization shall not use medical management techniques to require an enrollee to use a method of contraception other than the method prescribed or ordered by a provider of health care.

12. A health maintenance organization must provide an accessible, transparent and expedited process which is not unduly burdensome by which an enrollee, or the authorized representative of the enrollee, may request an exception relating to any medical management technique used by the health maintenance organization to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

13. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 46. *1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education

during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the enrollee or as ordered by a provider of health care;

(i) Smoking cessation programs for an enrollee who is 18 years of age or older not more than two cessation attempts per year and four counseling sessions per year;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or

other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 47. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, ~~[695C.1735 to]~~ ***695C.1751,*** 695C.1755, ~~[inclusive,]~~ 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708, 695C.1731, 695C.17345 ~~[and]~~ ***, 695C.1735, 695C.1745 and*** 695C.1757 ***and sections 45 and 46 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 48. NRS 695C.1694 is hereby amended to read as follows:

695C.1694 1. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** health maintenance organization which offers or issues a health care plan that provides coverage for prescription drugs or devices shall include in the plan coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~

~~"]~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. A health maintenance organization that offers or issues a health care plan that provides coverage for prescription drugs shall not:

(a) Require an enrollee to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for ~~[a prescription for a contraceptive or]~~ hormone replacement therapy ***;*** ~~[than is required for other prescription drugs covered by the plan;]~~

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee.

3. ~~[Except as otherwise provided in subsection 5, evidence]~~ ***Evidence*** of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. The provisions of this section do not ~~[:~~

~~(a) Require]~~ ***require*** a health maintenance organization to provide coverage for fertility drugs.

~~[(b) Prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the enrollee is required to pay for other prescription drugs covered by the plan.]~~

5. ~~[A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective~~

~~enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

~~6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.~~] As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 49. NRS 695C.1695 is hereby amended to read as follows:

695C.1695 1. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** health maintenance organization that offers or issues a health care plan which provides coverage for outpatient care shall include in the plan coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. A health maintenance organization that offers or issues a health care plan that provides coverage for outpatient care shall not:

(a) Require an enrollee to pay a higher deductible, ***any*** copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy ***;*** ~~[than is required for other outpatient care covered by the plan;]~~

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee.

3. ~~[Except as otherwise provided in subsection 5, evidence]~~ ***Evidence*** of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1,

1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. ~~[The provisions of this section do not prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the enrollee is required to pay for other outpatient care covered by the plan.~~

~~5. A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

~~6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 50. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health ~~[maintenance]~~ ***care*** plan ***of a health maintenance organization*** must provide coverage for benefits payable for expenses incurred for ~~[~~:

~~(a) An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40;and~~

~~(c) An annual]~~ ***a*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older.

2. ~~[A health maintenance plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an***

enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any benefit provided in the health care plan pursuant to subsection 1;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

~~[3.]~~ ***4.*** A ~~[policy]~~ ***health care plan*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the ~~[policy]~~ ***plan*** or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and

delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 51. NRS 695C.1745 is hereby amended to read as follows:

695C.1745 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age and older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A health care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.***

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny,

reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

~~[3.]~~ ***4.*** Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of]~~

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~[, "human]~~ ***:***

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 52. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant

to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and sections 45 and 46 of this act*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional

groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 53. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 54, 55 and 56 of this act.

Sec. 54. ***1. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 8; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 8;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same health care plan;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Voluntary sterilization for women; and

(f) Hormone replacement therapy.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsections 6, 7 and 9, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or

other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. Except as otherwise provided in subsection 5, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. A managed care organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the managed care organization objects on religious grounds. Such an organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

6. A managed care organization may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

7. For each of the 18 methods of contraception listed in subsection 8 that has been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the managed care organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

8. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;
(b) Surgical sterilization implants for women;
(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
(r) Antiprogestin-based drugs for emergency contraception.

9. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

10. A managed care organization shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

11. A managed care organization must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the managed care organization to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

12. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and

delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug;

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 55. *1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Hormone replacement therapy;

(e) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(f) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(g) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the

virus during the lifetime of the insured or as ordered by a provider of health care;

(j) Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;

(k) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management

techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 56. *1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.*

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 57. NRS 695G.171 is hereby amended to read as follows:

695G.171 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age and older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.***

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in a health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

~~[3.]~~ ***4.*** An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of]~~

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~[, "human]~~ ***:***

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which

is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 58. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 59. This act becomes effective on January 1, 2018.

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