Amendment No. 219

Senate Amendment to Senate Bill No. 217 (BDR 40-24)
Proposed by: Senate Committee on Health and Human Services
Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 217 (§ 12).

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

EWR/BJF Date: 4/17/2025

S.B. No. 217—Makes revisions relating to reproductive health care. (BDR 40-24)

SENATE BILL NO. 217–SENATORS CANNIZZARO, NGUYEN, SCHEIBLE, PAZINA, DONDERO LOOP; CRUZ-CRAWFORD, DALY, DOÑATE, FLORES, LANGE, NEAL, OHRENSCHALL AND TAYLOR

FEBRUARY 19, 2025

Referred to Committee on Health and Human Services

SUMMARY—Makes revisions relating to reproductive health care. (BDR 40-24)

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

CONTAINS UNFUNDED MANDATE (§ 12)
(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; prohibiting a governmental entity from substantially burdening certain activity relating to assisted reproduction under certain circumstances; authorizing a person whose engagement in such activity has been so burdened to assert the violation as a claim or defense in a judicial proceeding; authorizing a court to award damages against a governmental entity that substantially burdens such activity in certain circumstances; providing certain immunity from civil and criminal liability and administrative sanctions for certain persons and entities involved in the provision of assisted reproduction; providing that a fertilized egg or human embryo that exists before implantation in a human uterus is not a person for legal purposes; requiring certain health insurers to authorize a pregnant person to enroll in a health plan during a specified period; requiring certain public and private health insurers to provide certain coverage for the treatment of infertility and fertility preservation; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prescribes certain rights for a patient of a medical facility or a facility for the dependent. (NRS 449A.100-449A.124) **Sections 2-9** of this bill establish certain rights related to assisted reproduction. **Sections 3-6** define certain terms relating to assisted reproduction. **Section 7** applies the provisions of **sections 2-9** to certain state laws and all local laws and ordinances and the implementation of those laws and ordinances, regardless of when those laws or ordinances were enacted. **Section 8** generally prohibits a governmental entity from enacting or implementing any limitation or requirement that singles out assisted reproduction and substantially burdens: (1) the access of a person to assisted reproduction, any drug or device related to assisted reproduction or information related to assisted reproduction; (2) the ability of a provider of health care to provide assisted reproduction, any drug or device related

to assisted reproduction or information related to assisted reproduction within his or her scope of practice, training and experience; (3) the ability of a third party to provide insurance coverage of assisted reproduction or drugs or devices related to assisted reproduction; or (4) the ability of a person to control the use or disposition of his or her reproductive genetic material. **Section 8** creates an exception to such prohibitions if the governmental entity demonstrates by clear and convincing evidence that the burden, as applied to the person, provider of health care or third party who is subject to the burden: (1) furthers a compelling interest; and (2) is the least restrictive means of furthering that interest.

Section 8 authorizes a person, provider of health care or third party whose ability to access, provide or cover assisted reproduction, drugs or devices related to assisted reproduction or information related to assisted reproduction, or a person whose ability to control the use or disposition of his or her reproductive genetic material, is burdened to bring or defend an action in court and obtain appropriate relief. **Section 8** requires a court to award costs and attorney's fees to a person or entity who prevails on such a claim. **Section 8** additionally authorizes the Attorney General to bring an action to enjoin any limitation or requirement that violates **section 8**.

Section 9 provides that a person or entity is not subject to civil or criminal liability or administrative sanctions solely because the person or entity provides or receives goods or services related to assisted reproduction. **Section 9** also provides that the manufacturer of certain goods used to facilitate assisted reproduction is not subject to civil or criminal liability or administrative sanctions solely because of the death of or damage to an embryo. Under **section 9**, a person or entity is not immune from civil or criminal liability or administrative sanctions for acts or omissions that independently create liability or grounds for administrative sanctions, including, without limitation, negligence or providing services outside the scope of practice, training or experience of the person or entity. **Section 10** of this bill provides that a fertilized egg or human embryo that exists before implantation in the uterus of a human body is not a human being for any purpose under Nevada law.

Existing law prescribes certain requirements governing the availability of health insurance plans in this State. (NRS 687B.480, 689A.430-689A.460, 689B.300-689B.330, 695A.151-695A.157, 695B.340-695B.370, 695C.163-695C.169, 695F.440-695F.470) **Sections 12, 13, 15, 20, 24, 27-29, 32, 36, 38, 42 and 45** of this bill require a health insurer, including public and private employers who provide insurance for their employees ~~[,]~~ **but excluding certain group plans,** to provide a special enrollment period to a person determined by a qualified provider of health care to be pregnant, during which the pregnant person must be allowed to enroll in a health care plan outside of the period of open enrollment. **Sections 45.2 and 45.6 of this bill provide that until January 1, 2027, the requirements of section 45 to provide such a special enrollment period do not apply to Medicaid managed care plans.** **Section 17** of this bill provides for the enforcement of **section 15**, which governs private employers who provide health benefits to employees through a self-insured plan. **Section 18** of this bill establishes civil and criminal penalties for a violation of **section 15**, which are the same as the penalties for violations of other laws governing benefits provided by private employers. **Sections 21, 26, 34 and 39** of this bill make conforming changes to indicate the applicability of certain definitions to **sections 20, 24, 32 and 36**, respectively.

Existing law requires public and private policies of health insurance regulated under Nevada law to include certain coverage. (NRS 287.010, 287.04335, 422.2717-422.272428, 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1652-689C.169, 689C.194, 689C.1945, 689C.195, 689C.425, 695A.184-695A.1875, 695A.265, 695B.1901-695B.1948, 695C.050, 695C.1691-695C.176, 695G.162-695G.177) Existing law also requires employers to provide certain benefits for health care to employees, including the coverage required of health insurers, if the employer provides health benefits for its employees through a self-insured plan. (NRS 608.1555) **Sections** ~~[12-14,]~~ **12, 13, 23, 31, 37** ~~[, 38]~~ **and 44** of this bill require ~~[Medicaid and]~~ public and private health care plans for groups of more than ~~[100 insureds]~~ **50 employees or members** to include certain coverage for: (1) the treatment of infertility; and (2) the preservation of fertility where the insured has a medical condition or requires medical treatment that may cause infertility under certain circumstances. **Sections 14, 38.5, 45.6 and 47 of this bill impose similar requirements on Medicaid, beginning on January 1, 2027.** **Section 16** of this bill exempts employers who provide benefits for health care for their employees through a self-insured plan from ~~[those]~~ **the** requirements ~~[,]~~ **to cover services for the treatment or preservation of fertility.** **Sections 12-14, 19, 23, 31, 37,** ~~[38]~~

38.5 and 44 of this bill prohibit an insurer **, including Medicaid,** from imposing conditions, including cost-sharing, prior authorizations and waiting periods, on infertility treatment or fertility preservation if such conditions are not required for similar benefits that are not related to fertility. **Section 11** of this bill makes a conforming change to require the Director of the Department of Health and Human Services to administer the provisions of **section 14** in the same manner as other provisions relating to Medicaid. **Sections 25, 33 and 40** of this bill make conforming changes to clarify the applicability of provisions indicating that certain insurers are not required to cover fertility drugs.

Section 41 of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to provide the coverage required by **section 37**. The Commissioner is also authorized to take such action against other health insurers who fail to provide the coverage required by **sections 23 and 44**. (NRS 680A.200)

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

Section 1. Chapter 449A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 9, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 6, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Assisted reproduction" has the meaning ascribed to it in NRS 126.510.***

Sec. 4. ***"Gamete" has the meaning ascribed to it in NRS 126.560.***

Sec. 5. ***"Governmental entity" means the State of Nevada or any of its agencies or political subdivisions.***

Sec. 6. ***"Third party" means any insurer, governmental entity or other organization providing health coverage or benefits in accordance with state or federal law.***

Sec. 7. ***1. Except as otherwise provided in this section, the provisions of sections 2 to 9, inclusive, of this act apply to all state and local laws and ordinances and the implementation of those laws and ordinances, whether statutory or otherwise, and whether enacted before, on or after July 1, 2025.***

2. State laws that are enacted on or after July 1, 2025, are subject to the provisions of sections 2 to 9, inclusive, of this act unless the law explicitly excludes such application by reference to this section.

3. The provisions of sections 2 to 9, inclusive, of this act do not authorize a governmental entity to burden:

(a) The access of any person to assisted reproduction, any drug or device related to assisted reproduction or information related to assisted reproduction;

(b) The ability of a provider of health care to provide assisted reproduction or information related to assisted reproduction or to provide, administer, dispense or prescribe any drug or device related to assisted reproduction within the scope of practice, training and experience of the provider of health care;

(c) The ability of a third party to provide coverage of assisted reproduction or drugs or devices related to assisted reproduction; or

(d) The ability of a person to control the use or disposition of his or her gametes or other reproductive genetic material.

Sec. 8. ***1. Except as otherwise provided in this section, a governmental entity shall not enact or implement any limitation or requirement that:***

(a) Expressly, effectively, implicitly or, as implemented, singles out assisted reproduction or any drug or device related to assisted reproduction and substantially burdens:

(1) The access of a person to assisted reproduction, any drug or device related to assisted reproduction or information related to assisted reproduction;

(2) The ability of a provider of health care to:

(I) Provide assisted reproduction or information related to assisted reproduction within the scope of practice, training and experience of the provider of health care; or

(II) Provide, administer, dispense or prescribe any drug or device related to assisted reproduction within the scope of practice, training and experience of the provider of health care; or

(3) The ability of a third party to provide coverage of assisted reproduction or drugs or devices related to assisted reproduction.

(b) Expressly, effectively, implicitly or, as implemented, substantially burdens the ability of a person to control the use or disposition of his or her gametes or other reproductive genetic material.

2. A governmental entity may enact a requirement or limitation described in subsection 1 if the governmental entity demonstrates by clear and convincing evidence that the burden imposed by the requirement or limitation described in subsection 1, as applied to the person, provider of health care or third party who is subject to the burden:

(a) Furthers a compelling interest; and

(b) Is the least restrictive means of furthering that interest.

3. Notwithstanding any provision of NRS 41.0305 to 41.039, inclusive, but subject to the limitation on an award for damages set forth in NRS 41.035 when applicable, a person, provider of health care or third party who has been substantially burdened in violation of this section may assert that violation as a claim or defense in a judicial proceeding and obtain appropriate relief. A court shall award costs and attorney's fees to a person, provider of health care or third party who prevails on such a claim or defense pursuant to this section.

4. The Attorney General may bring an action in any court of competent jurisdiction in the name of the State of Nevada on his or her own complaint or on the complaint of any person or entity to enjoin any violation or proposed violation of the provisions of this section.

5. A court may find that a person, provider of health care or third party is a vexatious litigant if the person, provider of health care or third party makes a claim within the scope of sections 2 to 9, inclusive, of this act which is without merit, fraudulent or otherwise intended to harass or annoy a person or entity. If a court finds that a person, provider of health care or third party is a vexatious litigant pursuant to this subsection, the court may deny standing to that person, provider of health care or third party to bring further claims which allege a violation of this section.

Sec. 9. *1. Except as otherwise provided in this section, a person or entity is not subject to civil or criminal liability, or discipline or other administrative sanctions imposed by a professional licensing board or other governmental entity, solely because the person or entity provides or receives goods or services related to assisted reproduction.*

2. Except as otherwise provided in this section, a person or entity that stores or transports embryos for the purpose of assisted reproduction or the manufacturer of goods used to facilitate the process of assisted reproduction or the transportation of embryos stored for the purpose of assisted reproduction is not subject to civil or criminal liability, or discipline or other administrative

sanctions imposed by a professional licensing board or other governmental entity, solely because of the death of or damage to an embryo.

3. The provisions of this section do not preclude:

(a) Civil liability for any act or omission that independently gives rise to such liability, including, without limitation, acts or omissions that are the result of negligence;

(b) Criminal liability for any act or omission that would otherwise constitute a crime; or

(c) The imposition of discipline or other administrative sanctions for any act or omission that would otherwise constitute grounds for discipline or other administrative sanctions, including, without limitation, providing services that are outside the scope of practice, training and experience of a person or entity.

Sec. 10. The preliminary chapter of NRS is hereby amended by adding thereto a new section to read as follows:

Any fertilized human egg or human embryo that exists in any form before implantation in the uterus of a human body is not an unborn child, a minor child, a person, a natural person or any other term that connotes a human being for any purpose under the law or regulations of this State or any political subdivision thereof.

Sec. 11. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and section 14 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 12. 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 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723, 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, ***and section 23 of this act,*** paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, 689B.265, 689B.287 and 689B.500 ***and section 24 of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378,

689B.03785 and 689B.500 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. 13. 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 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, ***and section 44 of this act,*** 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, ***and section 45 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. 14. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. To the extent that federal financial participation is available, the Director shall , except as otherwise provided in subsection 4, include under Medicaid coverage for:

(a) Any procedure or medication determined by a qualified provider of health care to be necessary for the diagnosis and treatment of infertility in accordance with established medical practice or any guidelines published by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine, or their successor organizations. Such coverage must include, without limitation, coverage for:

(1) At least three but not more than five completed retrievals of oocytes; and

(2) ~~[Unlimited]~~ At least three but not more than five transfers of embryos, including, without limitation, single-embryo transfer where appropriate, in accordance with the guidelines of the American Society for Reproductive Medicine, or its successor organization.

(b) ~~[Any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that are determined by a qualified provider of health care to be medically]~~ At least 5 years of standard fertility preservation services that are necessary to preserve fertility because the recipient of Medicaid:

(1) Has been diagnosed with a medical or genetic condition that may directly or indirectly cause infertility, as determined pursuant to paragraph (a) of subsection 2; or

(2) Is expected to receive a medical treatment that may directly or indirectly cause infertility, as determined pursuant to paragraph (b) of subsection 2.

2. For the purposes of subsection 1:

(a) A medical or genetic condition may directly or indirectly cause infertility if the condition or treatment for the condition is likely to cause infertility, as established by the American Society of Clinical Oncology, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists, or their successor organizations.

(b) A medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. Medicaid must not:

(a) Require a recipient of Medicaid to pay a higher deductible, copayment, coinsurance or other form of cost-sharing for the benefits described in subsection 1 than is required for similar benefits that are not related to fertility;

(b) Require a recipient of Medicaid to obtain prior authorization for the benefits described in subsection 1 that is not required for similar benefits that are not related to fertility;

(c) Require a longer waiting period for the coverage required by subsection 1 than is required for similar benefits that are not related to fertility; or

(d) Impose any other exclusions, limitations, restrictions or delays on the access of a recipient of Medicaid to the goods and services described in subsection 1 that is not imposed on similar benefits that are not related to fertility.

4. Medicaid is not required to provide coverage pursuant to subsection 1 for a recipient whose infertility is solely caused by a voluntary sterilization procedure that has not been successfully reversed.

5. The Department shall:

(a) Apply to the Secretary of Health and Human Services for any waiver of federal law or apply for any amendment of the State Plan for Medicaid that is necessary for the Department to receive federal funding to provide the coverage described in subsection 1.

(b) Fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to paragraph (a).

~~5.~~ ***6. As used in this section:***

(a) "Infertility" means a condition characterized by:

(1) The inability of a person to achieve pregnancy, not including conception resulting in a miscarriage, where the person and the partner of the person or a donor have the necessary gametes to achieve pregnancy and after:

(I) At least 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is less than 35 years of age; or

(II) At least 6 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is 35 years of age or older;

(2) The inability of a person or the partner of the person to reproduce or the inability of a person to reproduce with a particular partner; or

(3) A finding by a qualified provider of health care that a person is infertile based on:

(I) The medical, sexual and reproductive history or age of the person;

(II) Physical findings; or

(III) Diagnostic testing.

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

(c) "Standard fertility preservation services":

(1) Means a procedure or services for the preservation of fertility that:

(I) Is not considered experimental or investigational by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization; and

(II) Is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization.

(2) Includes, without limitation, sperm banking, oocyte banking, embryo banking, banking of reproductive tissues and the storage of reproductive cells and tissues.

Sec. 15. Chapter 608 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Regardless of whether an employee who is pregnant already has health coverage, an employer who provides benefits for health care to his or her employees shall , except as otherwise provided in subsection 3, ensure that the employee is allowed to enroll in any plan to provide such benefits without any additional fee or penalty within at least 30 days after the employee has been confirmed to be pregnant by a qualified provider of health care.

2. Coverage for an employee who enrolls in a plan to provide benefits for health care pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the employee is pregnant; or

(b) Upon the election of the employee, on the first day of the month after the employee elects to enroll in the plan.

3. The provisions of this section do not apply to a cafeteria plan, as defined in 26 U.S.C. § 125(d).

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

Sec. 16. NRS 608.1555 is hereby amended to read as follows:

608.1555 ~~[Any]~~ ***1. Except as otherwise provided in this section, any*** employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by NRS 687B.409, 687B.723 and 687B.725.

2. An employer who employs less than 100 employees and provides benefits for health care to his or her employees through a plan of self-insurance is exempt from the requirements of section 23 of this act.

Sec. 17. NRS 608.180 is hereby amended to read as follows:

608.180 The Labor Commissioner or the representative of the Labor Commissioner shall cause the provisions of NRS 608.005 to 608.195, inclusive, ***and section 15 of this act*** and 608.215 to be enforced, and upon notice from the Labor Commissioner or the representative:

1. The district attorney of any county in which a violation of those sections has occurred;
2. The Deputy Labor Commissioner, as provided in NRS 607.050;
3. The Attorney General, as provided in NRS 607.160 or 607.220; or
4. The special counsel, as provided in NRS 607.065,

➥ shall prosecute the action for enforcement according to law.

Sec. 18. NRS 608.195 is hereby amended to read as follows:

608.195 1. Except as otherwise provided in NRS 608.0165, any person who violates any provision of NRS 608.005 to 608.195, inclusive, ***and section 15 of this act*** or 608.215, or any regulation adopted pursuant thereto, is guilty of a misdemeanor.

2. In addition to any other remedy or penalty, the Labor Commissioner may impose against the person an administrative penalty of not more than $5,000 for each such violation.

Sec. 19. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437, 689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312, 689B.0313, 689B.0315, 689B.0317, 689B.0319, 689B.0374, 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676, 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924, 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713, 695C.1735, 695C.1737, 695C.1743, 695C.1745, 695C.1751, 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715, 695G.1719 and 695G.177, ***and sections 23, 31, 37 and 44 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Unless a shorter time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703, respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 20. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Regardless of whether a person who is pregnant already has health coverage, an insurer shall allow the person to enroll in a policy of health insurance without any additional fee or penalty within at least 60 days after the person has been confirmed to be pregnant by a qualified provider of health care.

2. Coverage for a person who enrolls in a policy of health insurance pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the policy.

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

Sec. 21. NRS 689A.420 is hereby amended to read as follows:

689A.420 As used in NRS 689A.420 to 689A.460, inclusive, ***and section 20 of this act,*** unless the context otherwise requires:

1. "Medicaid" means a program established in any state pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

2. "Order for medical coverage" means an order of a court or administrative tribunal to provide coverage under a policy of health insurance to a child pursuant to the provisions of 42 U.S.C. § 1396g-1.

Sec. 22. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 23 and 24 of this act.

Sec. 23. ***1. Except as otherwise provided in ~~[subsection]~~ subsections 5 ~~[,]~~ and 6, an insurer that issues a policy of group health insurance with more than ~~[100 insureds]~~ 50 employees or members of the insured group shall include in the policy coverage for:***

(a) Any procedure or medication determined by a qualified provider of health care to be necessary for the diagnosis and treatment of infertility in accordance with established medical practice or any guidelines published by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine, or their successor organizations. Such coverage must include, without limitation, coverage for:

(1) At least three but not more than five completed retrievals of oocytes; and

(2) ~~[Unlimited]~~ At least three but not more than five transfers of embryos, including, without limitation, single-embryo transfer where appropriate, in accordance with the guidelines of the American Society for Reproductive Medicine, or its successor organization.

(b) ~~[Any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society~~

~~for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that are determined by a qualified provider of health care to be medically~~ At least 5 years of standard fertility preservation services that are necessary to preserve fertility because the insured:

(1) Has been diagnosed with a medical or genetic condition that may directly or indirectly cause infertility, as determined pursuant to paragraph (a) of subsection 2; or

(2) Is expected to receive a medical treatment that may directly or indirectly cause infertility, as determined pursuant to paragraph (b) of subsection 2.

2. For the purposes of subsection 1:

(a) A medical or genetic condition may directly or indirectly cause infertility if the condition or treatment for the condition is likely to cause infertility, as established by the American Society of Clinical Oncology, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists, or their successor organizations.

(b) A medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. An insurer shall 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.

4. An insurer shall not:

(a) Require an insured to pay a higher deductible, copayment, coinsurance or other form of cost-sharing for the benefits required by subsection 1 than is required for similar benefits that are not related to fertility;

(b) Require an insured to obtain prior authorization for the benefits described in subsection 1 that is not required for similar benefits that are not related to fertility;

(c) Require a longer waiting period for the coverage required by subsection 1 than is required for similar benefits that are not related to fertility;

(d) Impose any other exclusions, limitations, restrictions or delays on the access of an insured to any benefit described in subsection 1 that is not imposed on similar benefits that are not related to fertility;

(e) 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 benefit described in subsection 1;

(f) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any benefit described in subsection 1;

(g) Penalize a provider of health care who provides any benefit described in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(h) 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 benefit described in subsection 1 to an insured.

5. An insurer is not required to provide the coverage required by subsection 1 for an insured whose infertility is solely caused by a voluntary sterilization procedure that has not been successfully reversed.

6. An insurer that 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 that is subject to the requirements of subsection 1 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.]~~ 7. A policy of group health insurance with more than ~~[100 insureds]~~ 50 employees or members of the insured group that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal that conflicts with the provisions of this section is void.

~~[7.]~~ 8. As used in this section:

(a) "Infertility" means a condition characterized by:

(1) The inability of a person to achieve pregnancy, not including conception resulting in a miscarriage, where the person and the partner of the person or a donor have the necessary gametes to achieve pregnancy and after:

(I) At least 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is less than 35 years of age; or

(II) At least 6 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is 35 years of age or older;

(2) The inability of a person or the partner of the person to reproduce or the inability of a person to reproduce with a particular partner; or

(3) A finding by a qualified provider of health care that a person is infertile based on:

(I) The medical, sexual and reproductive history or age of the person;

(II) Physical findings; or

(III) Diagnostic testing.

(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) "Standard fertility preservation services":

(1) Means a procedure or services for the preservation of fertility that:

(I) Is not considered experimental or investigational by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization; and

(II) Is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization.

(2) Includes, without limitation, sperm banking, oocyte banking, embryo banking, banking of reproductive tissues and the storage of reproductive cells and tissues.

Sec. 24. *1. Regardless of whether a person who is pregnant already has health coverage, an insurer shall , except as otherwise provided in subsection 3, allow the person to enroll in a policy of group health insurance without any additional fee or penalty within at least 30 days after the person has been confirmed to be pregnant by a qualified provider of health care.*

2. Coverage for a person who enrolls in a policy of group health insurance pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the policy.

3. The provisions of this section do not apply to a cafeteria plan, as defined in 26 U.S.C. § 125(d).

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

Sec. 25. NRS 689B.0376 is hereby amended to read as follows:

689B.0376 1. 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 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 hormone replacement therapy;

(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 hormone replacement therapy;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing hormone replacement therapy;

(d) Penalize a provider of health care who provides 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 hormone replacement therapy to an insured.

3. 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 require an insurer to provide coverage for fertility drugs ~~[.]~~ ***, except as required by section 23 of this act.***

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

Sec. 26. NRS 689B.290 is hereby amended to read as follows:

689B.290 As used in NRS 689B.290 to 689B.330, inclusive, ***and section 24 of this act,*** unless the context otherwise requires:

1. "Medicaid" means a program established in any state pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

2. "Order for medical coverage" means an order of a court or administrative tribunal to provide coverage under a group health policy to a child pursuant to the provisions of 42 U.S.C. § 1396g-1.

Sec. 27. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Regardless of whether a person who is pregnant already has health coverage, a carrier shall , except as otherwise provided in subsection 3, allow the person to enroll in a health benefit plan without any additional fee or penalty

within at least 30 days after the person has been confirmed to be pregnant by a qualified provider of health care.

2. Coverage for a person who enrolls in a health benefit plan pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the health benefit plan.

3. The provisions of this section do not apply to a cafeteria plan, as defined in 26 U.S.C. § 125(d).

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

Sec. 28. 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 section 27 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. 29. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Regardless of whether a person who is pregnant already has health coverage, a society shall allow the person to enroll in a benefit contract without any additional fee or penalty within at least 60 days after the person has been confirmed to be pregnant by a qualified provider of health care.

2. Coverage for a person who enrolls in a benefit contract pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the benefit contract.

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

Sec. 30. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 31 and 32 of this act.

Sec. 31. ***1. Except as otherwise provided in ~~[subsection]~~ subsections 5 ~~[,]~~ and 6, a hospital or medical services corporation that issues a policy of group health insurance with more than ~~[100 insureds]~~ 50 employees or members of the insured group shall include in the policy coverage for:***

(a) Any procedure or medication determined by a qualified provider of health care to be necessary for the diagnosis and treatment of infertility in accordance with established medical practice or any guidelines published by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine, or their successor organizations. Such coverage must include, without limitation, coverage for:

(1) At least three but not more than five completed retrievals of oocytes; and

(2) ~~[Unlimited]~~ At least three but not more than five transfers of embryos, including, without limitation, single-embryo transfer where appropriate, in accordance with the guidelines of the American Society for Reproductive Medicine, or its successor organization.

(b) ~~[Any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that are determined by a qualified provider of health care to be medically]~~ At least 5 years of standard fertility preservation services that are necessary to preserve fertility because the insured:

(1) Has been diagnosed with a medical or genetic condition that may directly or indirectly cause infertility, as determined pursuant to paragraph (a) of subsection 2; or

(2) Is expected to receive a medical treatment that may directly or indirectly cause infertility, as determined pursuant to paragraph (b) of subsection 2.

2. For the purposes of subsection 1:

(a) A medical or genetic condition may directly or indirectly cause infertility if the condition or treatment for the condition is likely to cause infertility, as established by the American Society of Clinical Oncology, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists, or their successor organizations.

(b) A medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. A hospital or medical services corporation shall 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 hospital or medical services corporation.

4. A hospital or medical services corporation shall not:

(a) Require an insured to pay a higher deductible, copayment, coinsurance or other form of cost-sharing for the benefits required by subsection 1 than is required for similar benefits that are not related to fertility;

(b) Require an insured to obtain prior authorization for the benefits described in subsection 1 that is not required for similar benefits that are not related to fertility;

(c) Require a longer waiting period for the coverage required by subsection 1 than is required for similar benefits that are not related to fertility;

(d) Impose any other exclusions, limitations, restrictions or delays on the access of an insured to any benefit described in subsection 1 that is not imposed on similar benefits that are not related to fertility;

(e) 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 benefit described in subsection 1;

(f) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any benefit described in subsection 1;

(g) Penalize a provider of health care who provides any benefit described in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(h) 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 benefit described in subsection 1 to an insured.

5. A hospital or medical services corporation is not required to provide the coverage required by subsection 1 for an insured whose infertility is solely caused by a voluntary sterilization procedure that has not been successfully reversed.

6. A hospital or medical services corporation that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the hospital or medical services corporation objects on religious grounds. Such a hospital or medical services corporation shall, before the issuance of a policy of group health insurance that is subject to the requirements of subsection 1 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 hospital or medical services corporation refuses to provide pursuant to this subsection.

~~[6.]~~ 7. A policy of group health insurance with more than ~~[100 insureds]~~ 50 employees or members of the insured group that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal that conflicts with the provisions of this section is void.

~~[7.]~~ 8. As used in this section:

(a) "Infertility" means a condition characterized by:

(1) The inability of a person to achieve pregnancy, not including conception resulting in a miscarriage, where the person and the partner of the person or a donor have the necessary gametes to achieve pregnancy and after:

(I) At least 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is less than 35 years of age; or

(II) At least 6 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is 35 years of age or older;

(2) The inability of a person or the partner of the person to reproduce or the inability of a person to reproduce with a particular partner; or

(3) A finding by a qualified provider of health care that a person is infertile based on:

(I) The medical, sexual and reproductive history or age of the person;

(II) Physical findings; or

(III) Diagnostic testing.

(b) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation 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 hospital or medical services corporation. 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) "Standard fertility preservation services":

(1) Means a procedure or services for the preservation of fertility that:

(I) Is not considered experimental or investigational by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization; and

(II) Is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization.

(2) Includes, without limitation, sperm banking, oocyte banking, embryo banking, banking of reproductive tissues and the storage of reproductive cells and tissues.

Sec. 32. *1. Regardless of whether a person who is pregnant already has health coverage, a corporation shall , except as otherwise provided in subsection*

3. allow the person to enroll in a policy of health insurance without any additional fee or penalty within at least:

(a) Sixty days after the person has been confirmed to be pregnant by a qualified provider of health care, if the policy is offered on the individual market; or

(b) Thirty days after the person has been confirmed to be pregnant by a qualified provider of health care, if the policy is offered on the group market.

2. Coverage for a person who enrolls in a policy of health insurance pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the policy.

3. The provisions of this section do not apply to a cafeteria plan, as defined in 26 U.S.C. § 125(d).

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

Sec. 33. NRS 695B.1916 is hereby amended to read as follows:

695B.1916 1. 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 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 hormone replacement therapy;

(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 hormone replacement therapy;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing hormone replacement therapy;

(d) Penalize a provider of health care who provides 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 hormone replacement therapy to an insured.

3. 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 require an insurer to provide coverage for fertility drugs ~~[.]~~ ***, except as required by section 31 of this act.***

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

Sec. 34. NRS 695B.330 is hereby amended to read as follows:

695B.330 As used in NRS 695B.330 to 695B.370, inclusive, ***and section 32 of this act,*** unless the context otherwise requires:

1. "Contract" means a contract for hospital, medical or dental services issued pursuant to this chapter.

2. "Corporation" means a corporation organized pursuant to this chapter.

3. "Medicaid" means a program established in any state pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

4. "Order for medical coverage" means an order of a court or administrative tribunal to provide coverage under a contract to a child pursuant to the provisions of 42 U.S.C. § 1396g-1.

Sec. 35. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 36 and 37 of this act.

Sec. 36. ***1. Regardless of whether a person who is pregnant already has health coverage, a health maintenance organization shall , except as otherwise provided in subsection 3, allow the person to enroll in a health care plan without any additional fee or penalty within at least:***

(a) Sixty days after the person has been confirmed to be pregnant by a qualified provider of health care, if the health care plan is offered on the individual market; or

(b) Thirty days after the person has been confirmed to be pregnant by a qualified provider of health care, if the health care plan is offered on the group market.

2. Coverage for a person who enrolls in a health care plan pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the plan.

3. The provisions of this section do not apply to a cafeteria plan, as defined in 26 U.S.C. § 125(d).

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

Sec. 37. ***1. Except as otherwise provided in [subsection] subsections 5 [,] and 6, a health maintenance organization that issues a group health care plan with more than [100 enrollees] 50 employees or members of the covered group or a plan that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid shall include in the plan coverage for:***

(a) Any procedure or medication determined by a qualified provider of health care to be necessary for the diagnosis and treatment of infertility in accordance with established medical practice or any guidelines published by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine, or their successor organizations. Such coverage must include, without limitation, coverage for:

(1) At least three but not more than five completed retrievals of oocytes; and

(2) [Unlimited] At least three but not more than five transfers of embryos, including, without limitation, single-embryo transfer where appropriate, in accordance with the guidelines of the American Society for Reproductive Medicine, or its successor organization.

(b) [Any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their

~~*successor organizations, that are determined by a qualified provider of health care to be medically]*~~ *At least 5 years of standard fertility preservation services that are necessary to preserve fertility because the enrollee:*

(1) Has been diagnosed with a medical or genetic condition that may directly or indirectly cause infertility, as determined pursuant to paragraph (a) of subsection 2; or

(2) Is expected to receive a medical treatment that may directly or indirectly cause infertility, as determined pursuant to paragraph (b) of subsection 2.

2. For the purposes of subsection 1:

(a) A medical or genetic condition may directly or indirectly cause infertility if the condition or treatment for the condition is likely to cause infertility, as established by the American Society of Clinical Oncology, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists, or their successor organizations.

(b) A medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. A health maintenance organization shall 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.

4. A health maintenance organization shall not:

(a) Require an enrollee to pay a higher deductible, copayment, coinsurance or other form of cost-sharing for the benefits required by subsection 1 than is required for similar benefits that are not related to fertility;

(b) Require an enrollee to obtain prior authorization for the benefits described in subsection 1 that is not required for similar benefits that are not related to fertility;

(c) Require a longer waiting period for the coverage required by subsection 1 than is required for similar benefits that are not related to fertility;

(d) Impose any other exclusions, limitations, restrictions or delays on the access of an enrollee to any benefit described in subsection 1 that is not imposed on similar benefits that are not related to fertility;

(e) 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 benefit described in subsection 1;

(f) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing any benefit described in subsection 1;

(g) Penalize a provider of health care who provides any benefit described in subsection 1 to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(h) 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 benefit described in subsection 1 to an enrollee.

5. A health maintenance organization is not required to provide the coverage required by subsection 1 for an enrollee whose infertility is solely caused by a voluntary sterilization procedure that has not been successfully reversed.

6. A health maintenance organization 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 a health maintenance organization shall, before the issuance of a group health care plan that is subject to the requirements of subsection 1 and before the renewal of 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.

~~[6.]~~ 7. A group health care plan with more than ~~[100 enrollees]~~ 50 employees or members of the covered group that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal that conflicts with the provisions of this section is void.

~~[7.]~~ 8. As used in this section:

(a) "Infertility" means a condition characterized by:

(1) The inability of a person to achieve pregnancy, not including conception resulting in a miscarriage, where the person and the partner of the person or a donor have the necessary gametes to achieve pregnancy and after:

(I) At least 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is less than 35 years of age; or

(II) At least 6 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is 35 years of age or older;

(2) The inability of a person or the partner of the person to reproduce or the inability of a person to reproduce with a particular partner; or

(3) A finding by a qualified provider of health care that a person is infertile based on:

(I) The medical, sexual and reproductive history or age of the person;

(II) Physical findings; or

(III) Diagnostic testing.

(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) "Standard fertility preservation services":

(1) Means a procedure or services for the preservation of fertility that:

(I) Is not considered experimental or investigational by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization; and

(II) Is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization.

(2) Includes, without limitation, sperm banking, oocyte banking, embryo banking, banking of reproductive tissues and the storage of reproductive cells and tissues.

Sec. 38. 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.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, and 695C.265 ***and section 37 of this act*** 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.16932 to 695C.1699, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1736 to 695C.1745, inclusive, 695C.1757 and 695C.204 ***and ~~[sections]~~ section 36 ~~[and 37]~~ 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.

6. The provisions of NRS 695C.17095 do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

7. The provisions of NRS 695C.1735 do not apply to a health maintenance organization that provides health care services to:

(a) The officers and employees, and the dependents of officers and employees, of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State; or

(b) Members of the Public Employees' Benefits Program.

➥ This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 38.5. **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.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, and 695C.265 ~~[and section 37 of this act]~~ 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.16932 to 695C.1699, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1736 to 695C.1745, inclusive, 695C.1757 and 695C.204 and ~~[section]~~ ***sections*** 36***, and 37*** 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.

6. The provisions of NRS 695C.17095 do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

7. The provisions of NRS 695C.1735 do not apply to a health maintenance organization that provides health care services to:

(a) The officers and employees, and the dependents of officers and employees, of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State; or

(b) Members of the Public Employees' Benefits Program.

➥ This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 39. NRS 695C.161 is hereby amended to read as follows:

695C.161 As used in NRS 695C.161 to 695C.169, inclusive, ***and section 36 of this act,*** unless the context otherwise requires:

1. "Medicaid" means a program established in any state pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

2. "Order for medical coverage" means an order of a court or administrative tribunal to provide coverage under a health care plan to a child pursuant to the provisions of 42 U.S.C. § 1396g-1.

Sec. 40. NRS 695C.1694 is hereby amended to read as follows:

695C.1694 1. 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 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 hormone replacement therapy;

(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 hormone replacement therapy;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing hormone replacement therapy;

(d) Penalize a provider of health care who provides 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 hormone replacement therapy to an enrollee.

3. 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 require a health maintenance organization to provide coverage for fertility drugs ~~[.]~~ ***, except as required by section 37 of this act.***

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

Sec. 41. 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 section 37 of this act,*** 695C.204 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 or creditors or to the general public;

(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. 42. Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

1. Regardless of whether a person who is pregnant already has health coverage, a prepaid limited health service organization that offers coverage for pregnancy and childbirth shall allow the person to enroll in such coverage without any additional fee or penalty within at least 60 days after the person has been confirmed to be pregnant by a qualified provider of health care.

2. Coverage for a person who enrolls in coverage pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the coverage.

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

Sec. 43. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 44 and 45 of this act.

Sec. 44. ***1. Except as otherwise provided in [subsection] subsections 5 [,] and 6, a managed care organization that issues a group health care plan with more than [100 insureds] 50 employees or members of the insured group or a plan that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid shall include in the plan coverage for:***

(a) Any procedure or medication determined by a qualified provider of health care to be necessary for the diagnosis and treatment of infertility in accordance with established medical practice or any guidelines published by the American

College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine, or their successor organizations. Such coverage must include, without limitation, coverage for:

(1) At least three but not more than five completed retrievals of oocytes; and

(2) ~~[Unlimited]~~ At least three but not more than five transfers of embryos, including, without limitation, single-embryo transfer where appropriate, in accordance with the guidelines of the American Society for Reproductive Medicine, or its successor organization.

(b) ~~[Any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that are determined by a qualified provider of health care to be medically]~~ At least 5 years of standard fertility preservation services that are necessary to preserve fertility because the insured:

(1) Has been diagnosed with a medical or genetic condition that may directly or indirectly cause infertility, as determined pursuant to paragraph (a) of subsection 2; or

(2) Is expected to receive a medical treatment that may directly or indirectly cause infertility, as determined pursuant to paragraph (b) of subsection 2.

2. For the purposes of subsection 1:

(a) A medical or genetic condition may directly or indirectly cause infertility if the condition or treatment for the condition is likely to cause infertility, as established by the American Society of Clinical Oncology, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists, or their successor organizations.

(b) A medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. A managed care organization shall 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.

4. A managed care organization shall not:

(a) Require an insured to pay a higher deductible, copayment, coinsurance or other form of cost-sharing for the benefits required by subsection 1 than is required for similar benefits that are not related to fertility;

(b) Require an insured to obtain prior authorization for the benefits described in subsection 1 that is not required for similar benefits that are not related to fertility;

(c) Require a longer waiting period for the coverage required by subsection 1 than is required for similar benefits that are not related to fertility;

(d) Impose any other exclusions, limitations, restrictions or delays on the access of an insured to any benefit described in subsection 1 that is not imposed on similar benefits that are not related to fertility;

(e) Refuse to issue a group health care plan or cancel a group health care plan solely because the person applying for or covered by the plan uses or may use in the future any benefit described in subsection 1;

(f) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any benefit described in subsection 1;

(g) Penalize a provider of health care who provides any benefit described in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(h) 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 benefit described in subsection 1 to an insured.

5. A managed care organization is not required to provide the coverage required by subsection 1 for an insured whose infertility is solely caused by a voluntary sterilization procedure that has not been successfully reversed.

6. A managed care organization that 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 a managed care organization shall, before the issuance of a group health care plan that is subject to the requirements of subsection 1 and before the renewal of such a plan, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

~~[6.]~~ *7. A group health care plan with more than ~~[100 insureds]~~ 50 employees or members of the insured group that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal that conflicts with the provisions of this section is void.*

~~[7.]~~ *8. As used in this section:*

(a) "Infertility" means a condition characterized by:

(1) The inability of a person to achieve pregnancy, not including conception resulting in a miscarriage, where the person and the partner of the person or a donor have the necessary gametes to achieve pregnancy and after:

(I) At least 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is less than 35 years of age; or

(II) At least 6 months of regular, unprotected sexual intercourse or therapeutic donor insemination for a person who is 35 years of age or older;

(2) The inability of a person or the partner of the person to reproduce or the inability of a person to reproduce with a particular partner; or

(3) A finding by a qualified provider of health care that a person is infertile based on:

(I) The medical, sexual and reproductive history or age of the person;

(II) Physical findings; or

(III) Diagnostic testing.

(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) "Standard fertility preservation services":

(1) Means a procedure or services for the preservation of fertility that:

(I) Is not considered experimental or investigational by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization; and

(II) Is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine, or its successor organization, or the American Society of Clinical Oncology, or its successor organization.

(2) Includes, without limitation, sperm banking, oocyte banking, embryo banking, banking of reproductive tissues and the storage of reproductive cells and tissues.

Sec. 45. ***1. Regardless of whether a person who is pregnant already has health coverage, a managed care organization shall , except as otherwise provided in subsection 3, allow the person to enroll in a health care plan without any additional fee or penalty within at least:***

(a) Sixty days after the person has been confirmed to be pregnant by a qualified provider of health care, if the health care plan is offered on the individual market; or

(b) Thirty days after the person has been confirmed to be pregnant by a qualified provider of health care, if the health care plan is offered on the group market.

2. Coverage for a person who enrolls in a health care plan pursuant to subsection 1 must be effective:

(a) Except as otherwise provided in paragraph (b), on the first day of the month in which a qualified provider of health care confirms that the person is pregnant; or

(b) Upon the election of the person, on the first day of the month after the person elects to enroll in the plan.

3. The provisions of this section do not apply to a cafeteria plan, as defined in 26 U.S.C. § 125(d).

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

Sec. 45.2. **NRS 695G.090 is hereby amended to read as follows:**

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.127, 695G.1639, 695G.164, 695G.1645, 695G.167 and 695G.200 to 695G.230, inclusive, ***and section 45 of this act*** do not apply to a managed care organization that provides health care services 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.

4. The provisions of NRS 695C.1735 and 695G.1639 do not apply to a managed care organization that provides health care services to members of the Public Employees' Benefits Program.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 45.6. **NRS 695G.090 is hereby amended to read as follows:**

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.127, 695G.1639, 695G.164, 695G.1645, 695G.167 and 695G.200 to 695G.230, inclusive, ~~[and section 45 of this act]~~ do not apply to a managed care organization that provides health care services 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.

4. The provisions of NRS 695C.1735 and 695G.1639 do not apply to a managed care organization that provides health care services to members of the Public Employees' Benefits Program.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 46. The provisions of subsection 1 of NRS 354.599 do not apply to any additional expenses of a local government which are related to the provisions of this act.

Sec. 47. 1. This section and section 10 of this act become effective upon passage and approval.

2. Sections 1 to 9, inclusive, of this act become effective on July 1, 2025.

3. Sections ~~[11]~~ **12, 13, 15** to **38, inclusive, 39 to 45.2, inclusive, and** 46 ~~[, inclusive,]~~ of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2026, for all other purposes.

4. Sections 11, 14, 38.5 and 45.6 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2027, for all other purposes.